SECTION 6: CLAIMS FILING

6.1 Claims Information

Because Texas Medicaid cannot make payments to clients, the provider who performs the service must file an assigned claim. 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. Providers cannot bill Texas Medicaid or Medicaid clients for missed appointments or failure to keep an appointment. Only claims for services rendered are considered for payment.

Medicaid providers are also required to complete and sign authorized medical transportation forms (e.g., Form 3103, Individual Driver Registrant (IDR) Service Record, or Form 3111, Verification of Travel to Healthcare Services by Mass Transit) or provide an equivalent (e.g., provider statement on official letterhead) to attest that services were provided to a client on a specific date. The client presents these forms to the provider.

Providers are not allowed to bill clients or Texas Medicaid for completing these forms.

6.1.1 TMHP Processing Procedures

TMHP processes claims for the Texas Medicaid fee-for-service and Medicaid Managed Care programs.

Medicaid claims are subject to the following procedures:

- TMHP verifies all required information is present.
- Claims filed under the same provider identifier and program and ready for disposition at the end of each week are paid to the provider with an explanation of each payment or denial. The explanation is called the Remittance and Status (R&S) Report, which may be received as a downloadable portable document format (PDF) version or on paper. A *Health Insurance Portability and Accountability Act* (HIPAA)-compliant 835 transaction file is also available for those providers who wish to import claim dispositions into a financial system.

  An R&S Report is generated for providers that have weekly claim or financial activity with or without payment. The report identifies pending, paid, denied, and adjusted claims. If no claim activity or outstanding account receivables exist during the time period, an R&S Report is not generated for the week.
- For services that are billed on a claim and have any benefit limitations for providers, the date of service determines which provider's claims are paid, denied, or recouped. Claims that have been submitted and paid may be recouped if a new claim with an earlier date of service is submitted, depending on the benefit limitations for the services rendered.

  Services that have been authorized for an extension of the benefit limitation will not be recouped. Providers can submit an appeal with medical documentation if the claim has been denied.

Refer to: Section 8, Managed Care" for TMHP claims processing information related to Medicaid Managed Care.

6.1.1.1 Fiscal Agent

TMHP acts as the state's Medicaid fiscal agent. A fiscal agent arrangement is one of two methods allowed under federal law and is used by all other states that contract with outside entities for Medicaid claims payment. Under the fiscal agent arrangement, TMHP is responsible for paying claims, and the state is responsible for covering the cost of claims.

Note: *The fiscal agent arrangement does not affect Long Term Care (LTC) and Family Planning (Titles V, X, XX) providers.*

Provider Designations
The fiscal agent arrangement requires that providers be designated as either public or nonpublic. By definition, public providers are those that are owned or operated by a city, state, county, or other government agency or instrumentality, according to the *Code of Federal Regulations*. In addition, any provider or agency that performs intergovernmental transfers to the state would be considered a public provider. This includes those agencies that can certify and provide state matching funds, (i.e., other state agencies). New providers self-designate (public or private) on the provider enrollment application.

The fiscal agent:

- Rejects all claims not payable under Texas Medicaid rules and regulations.
- Suspends payments to providers according to procedures approved by HHSC.
- Notifies providers of reduction in claim amount or rejection of claim and the reason for doing so.
- Collects payments made in error, affects a current record credit to the department, and provides the department with required data relating to such error corrections.
- Prepares checks or drafts to providers, except for cases in which the department agrees that a basis exists for further review, suspension, or other irregularity within a period not to exceed 30 days of receipt and determination of proper evidence establishing the validity of claims, invoices, and statements.
- Makes provisions for payments to providers who have furnished eligible client benefits.
- Withholds payment of claim when the eligible client has another source of payment.
- Employs and assigns a physician, or physicians, and other professionals as necessary, to establish suitable standards for the audit of claims for services delivered and payment to eligible providers.
- Requires eligible providers to submit information on claim forms.

6.1.1.2 Payment Error Rate Measurement (PERM)

The *Improper Payments Information Act* (IPIA) of 2002 directs federal agency heads, in accordance with the Office of Management and Budget (OMB) guidance, to annually review agency programs that are susceptible to significant erroneous payments and to report the improper payment estimates to the U.S. Congress.

Every three years the Centers for Medicaid and Medicare Services (CMS) will assess the Texas Medicaid Program using the PERM process to measure improper payments in the Texas Medicaid Program and the Children's Health Insurance Program (CHIP).

CMS uses PERM to measure the accuracy of Medicaid and CHIP payments made by states for services rendered to clients. Under the PERM program, CMS will use three national contractors to measure improper payments in Medicaid and CHIP:

- The statistical contractor will provide support to the program by identifying the claims to be reviewed and by calculating each state's error rate.
- The data documentation contractor will collect medical policies from the State and medical records from providers.
- The review contractor will perform medical and data processing reviews of the selected claims in order to identify any improper payments.

Providers are 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 CHIP claims.

Past studies have shown that the largest cause of error in medical reviews is lack of documentation or insufficient documentation. It is important that information be sent in a timely and complete manner, since a provider's failure to timely submit complete records in support of the claims filed can result in a higher payment error rate for Texas, which in turn can negatively impact the amount of federal funding received by Texas for Medicaid and CHIP.

Providers must submit the requested medical records to the data documentation contractor and HHSC within 60 calendar days of the receipt of the written notice of request. If providers have not responded within 15 days, the data documentation contractor and possibly state officials will initiate reminder calls and letters to providers. The data documentation contractor and possibly state officials will also initiate reminder calls and letters to providers after 35 days. If providers have not responded in 60 days, the data documentation contractor will submit a letter to the provider and the state PERM director indicating a "no documentation error". After the provider's submittal of requested information, the data documentation contractor may request additional information to determine proper payment. In this instance, the provider is given 15 days to provide additional documentation.

If medical records are not received within 60 calendar days, the data documentation contractor will identify the claim as a PERM error and classify all dollars associated with the claim as an overpayment. Providers will be required to reimburse the overpayment in accordance with state and federal requirements.

A provider's failure to maintain complete and correct documentation in support of claims filed or failure to provide such documentation upon request can result in the provider being sanctioned under Title 1, *Texas Administrative Code* (TAC) Part 15, Chapter 371. Sanction actions may include, but are not limited to, a finding of overpayment for the claims that are not sufficiently supported by the required documentation. Sanctions may include, but are not limited to, a finding of overpayment for the claims that are not sufficiently supported by the required documentation.

6.1.2 Claims Filing Instructions

This manual references paper claims when explaining filing instructions. HHSC and TMHP encourage providers to submit claims electronically. TMHP offers specifications for electronic claim formats. These specifications are available from the TMHP website and include a cross-reference of the paper claim filing requirements to the electronic format.

Providers can participate in the most efficient and effective method of submitting claims to TMHP by submitting claims through the TMHP Electronic Data Interchange (EDI) claims processing system using TexMedConnect or a third party vendor. The proceeding claim filing instructions in this manual apply to paper and electronic submitters. Although the examples of claims filing instructions refer to their inclusion on the paper claim form, claim data requirements apply to all claim submissions, regardless of the media. Claims must contain the provider's complete name, address, and provider identifier to avoid unnecessary delays in processing and payment.

Note: *Information about filing claims for services rendered to STAR Program and STAR+PLUS Program members is available in* Section 8, "Managed Care" (*Vol. 1, General Information*).

Exception: *File Primary Care Case Management (PCCM) claims with TMHP.*

Refer to: Section 3, TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on accessing the TMHP website.
Subsection 8.1, "Medicaid Managed Care" in Section 8, "Managed Care" (*Vol. 1, General Information*).

6.1.2.1 Tips on Expediting Paper Claims

Use the following guidelines to enhance the accuracy and timeliness of paper claims processing.

General requirements

- Use original claim forms. Don't use copies of claim forms.

- Detach claims at perforated lines before mailing.
- Use 10 x 13 inch envelopes to mail claims. Don't fold claim forms, appeals, or correspondence.
- Don't use labels, stickers, or stamps on the claim form.
- Don't send duplicate copies of information.
- Use 8 ½ x 11 inch paper. Don't use paper smaller or larger than 8 ½ x 11 inches.
- Don't mail claims with correspondence for other departments.

Data Fields

- Print claim data within defined boxes on the claim form.
- Use black ink, but not a black marker. Don't use red ink or highlighters.
- Use all capital letters.
- Print using 10-pitch (12-point) Courier font, 10 point. Don't use fonts smaller or larger than 12 points. Don't use proportional fonts, such as Arial or Times Roman.
- Use a laser printer for best results. Don't use a dot matrix printer, if possible.
- Don't use dashes or slashes in date fields.

Attachments

- Use paper clips on claims or appeals if they include attachments. Don't use glue, tape, or staples.
- Place the claim form on top when sending new claims, followed by any medical records or other attachments.
- Number the pages when sending when sending attachments or multiple claims for the same client (e.g., 1 of 2, 2 of 2).
- Don't total the billed amount on each claim form when submitting multi-page claims for the same client.
- Use the CMS-approved Medicare Remittance Advice Notice printed from Medicare Remit Easy Print (MREP) (professional services) or PC-Print (institutional services) when sending a Remittance Advice from Medicare or the paper MRAN received from Medicare or a Medicare intermediary. You may also download a TMHP-approved MRAN template from the TMHP website at www.tmhp.com.
- Submit claim forms with MRANs and R&S Reports.

6.1.3 Claims Filing Deadlines

For claims payment to be considered, providers must adhere to the time limits described in this section. Claims received after the following claims filing deadlines are not payable because Texas Medicaid does not provide coverage for late claims.

Exception: *Unless otherwise stated below, claims must be received by TMHP within 95 days from each date of service (DOS). Appeals must be received by TMHP within 120 days of the disposition date on the R&S Report on which the claim appears. A 95-day or 120-day appeal filing deadline that falls on a weekend or a holiday is extended to the next business day following the weekend or holiday.*

Only the following holidays extend the deadlines in 2010 and 2011:

Date	Holiday
January 1, 2010	New Year's Day
January 18, 2010	Martin Luther King, Jr. Day
February 15, 2010	President's Day
May 31, 2010	Memorial Day
September 6, 2010	Labor Day
October 11, 2010*	Columbus Day
November 11, 2010	Veteran's Day
November 25, 2010	Thanksgiving Day
November 26, 2010	Day After Thanksgiving
December 24, 2010	Christmas Eve
January 17, 2011	Martin Luther King, Jr. Day
February 21, 2011	Presidents Day
May 30, 2011	Memorial Day
July 4, 2011	Independence Day

*** Columbus Day is a federal holiday, but not a state holiday. The claims filing deadline will be extended for providers because the Post Office will not be operating on this day.**

The following are time limits for submitting claims:

- Inpatient claims filed by the hospital must be received by TMHP within 95 days of the discharge date or last DOS on the claim.
    - Hospitals reimbursed according to diagnosis-related group (DRG) payment methodology may submit an interim claim because the client has been in the facility 30 consecutive days or longer. A total stay claim is needed after discharge to ensure accurate calculation for potential outlier payments for clients 20 years of age or younger.
    - Children's hospitals reimbursed according to *Tax Equity and Fiscal Responsibility Act* (TEFRA) *of 1982* methodology may submit interim claims before discharge and must submit an interim claim if the client remains in the hospital past the hospital's fiscal year end.
- When medical services are rendered to a Medicaid client in Texas, TMHP must receive claims within 95 days of the DOS on the claim.
- 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 DOS.
- TMHP must receive claims from out-of-state providers within 365 days from the DOS. The DOS is the date the service is provided or performed.

- TMHP must receive claims on behalf of an individual who has applied for Medicaid coverage but has not been assigned a Medicaid number on the DOS within 95 days from the date the eligibility was added to the TMHP eligibility file (add date) and within 365 days of the date of service or from the discharge date for inpatient claims.

Providers should verify eligibility and add date by contacting TMHP (Automated Inquiry System [AIS], TMHP EDI's electronic eligibility verification, or TMHP Contact Center) when the number is received. Not all *applicants* become eligible *clients*. Providers that submit claims electronically within the 365-day federal filing deadline for services rendered to individuals who do not currently have a Texas Medicaid identification number will receive an electronic rejection. Providers can use the TMHP rejection report as proof of meeting the 365-day federal filing deadline and submit an administrative appeal.

Important: *Providers should request and keep copies of any Forms 1027 and H3087 submitted by clients. A copy is required during the appeal process if the client's eligibility becomes an issue.*

- If a client becomes retroactively eligible or loses Medicaid eligibility and is later determined to be eligible, the 95-day filing deadline begins on the date that the eligibility start date was added to TMHP files (the add date). However, the 365-day federal filing deadline must still be met.
- When a service is a benefit of Medicare and Medicaid, and the client is covered by both programs, the claim must be filed with Medicare first. TMHP *must* receive Medicaid claims within 95 days of the date of Medicare disposition.

Providers must submit a paper MRAN received from Medicare or a Medicare intermediary, the computer-generated MRANs from the Centers for Medicare & Medicaid Services (CMS)-approved software application MREP for professional services or PC-Print for institutional services, or the TMHP Standardized MRAN Form with a completed claim form to TMHP.

- When a client is eligible for Medicare Part B only, the inpatient hospital claim for services covered as Medicaid only is sent directly to TMHP and is subject to the 95-day filing deadline (from date of discharge).

  Note: *It is strongly recommended that providers who submit paper claims keep a copy of the documentation they send. It is also recommended that paper claims be sent by certified mail with a return receipt requested. This documentation, along with a detailed listing of the claims enclosed, provides proof that the claims were received by TMHP, which is particularly important if it is necessary to prove that the 95-day claims filing deadline has been met. TMHP will accept certification receipts as proof of the 95-day or 120-filing deadline. For this, the provider must provide the following: certification receipt, log to include information in the packet, Medicaid number, billed amount, DOS, and a signed claim copy. The provider needs to keep such proof of multiple claims submissions if the provider identifier is pending.*

- If the provider is attempting to obtain prior authorization for services performed or will be performed, TMHP must receive the claim according to the usual 95-day filing deadline.

  Note: *PCCM providers, refer to Section 8, "Managed Care"* (*Vol. 1, General Information*) *for additional information regarding authorizations.*

- The provider bills TMHP directly within 95 days from the DOS. However, if a non-third party resource (TPR) is billed first, TMHP must receive the claim within 95 days of the claim disposition by the other entity.

  Note: *The provider submits a copy of the disposition with the claim. A non-TPR is secondary to Texas Medicaid and may only pay benefits after Texas Medicaid.*

Refer to: Subsection 4.11, "Third Party Resources (TPR)" in Section 4, Client Eligibility (*Vol. 1, General Information*) for examples of non-TPRs.

- When a service is billed to another insurance resource, the filing deadline is 95 days from the date of disposition by the other resource.

- When a service is billed to a third party and no response has been received, Medicaid providers must allow 110 days to elapse before submitting a claim to TMHP. However, the 365-day federal filing deadline requirement must still be met.
- A Compass21 (C21) process allows a Title V, X, or XX Family Planning claim to be paid by Title XIX (Medicaid) if the client is eligible for Title XIX when those services are provided and billed under Title V, X, or XX. In this instance, the Medicaid 95-day filing deadline is in effect and must be met or the claim will be denied.
- For claims re-submitted to TMHP with additional detail charges, the additional details are subject to the 95-day filing deadline.

Note: *In accordance with federal regulations, all claims must be initially filed with TMHP within 365 days of the DOS, regardless of provider enrollment status or retroactive eligibility.*

Refer to: Subsection 6.1.2, "Claims Filing Instructions" in this section.

Subsection 1.1, "Provider Enrollment" in Section 1, Provider Enrollment and Responsibilities (*Vol. 1, General Information*) for information on the provider enrollment process.

Subsection 7.1, "Appeal Methods" in Section 7, "Appeals" (*Vol. 1, General Information*) for information on the process for submitting appeals.

Subsection 6.1.3.2, "Exceptions to the 95-Day Filing Deadline" in this section.

"Automated Inquiry System (AIS)" in TMHP Telephone and Address Guide (*Vol. 1, General Information*) to learn how to retrieve client eligibility information by telephone.

Subsection 4.11, "Third Party Resources (TPR)" in Section 4, Client Eligibility (*Vol. 1, General Information*).

Subsection 4.2, "Eligibility Verification" in Section 4, Client Eligibility (*Vol. 1, General Information*).

Subsection 6.11.7, "Provider Inquiries—Status of Claims" in this section.

6.1.3.1 Claims for Clients with Retroactive Eligibility

Claims for clients who receive retroactive eligibility must be submitted within 95 days of the date that the client's eligibility was added to the TMHP eligibility file (add date) and within 365 days of the DOS.

Title 42 of the Code of Federal Regulations (42 CFR), at 447.45 (d) (1), states "The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service." The 12-month filing deadline applies to all claims. Claims not submitted within 365 days (12 months) from the date of service cannot be considered for payment.

Retroactive eligibility does not constitute an exception to the federal filing deadline. Even if the patient's Medicaid eligibility determination is delayed, the provider must still submit the claim within 365 days of the date of service. A claim that is not submitted within 365 days of the date of service will not be considered for payment.

To submit a claim for services provided to a patient who is not yet eligible for Medicaid, Texas Medicaid allows providers to submit claims using a pseudo recipient identification number such as 999999999 or 000000000. Although TMHP will deny the claim, providers should retain the denial or electronic rejection report for proof of timely filing, especially if the eligibility determination occurs more than 365 days after the date of service. Claims denied for recipient ineligibility may be resubmitted when the patient becomes eligible for the retroactive date(s) of service. Texas Medicaid may then consider the claim for payment because the initial claim was submitted within the 365-day federal filing deadline and the denial was not the result of an error by the provider.

If the 365-day federal filing deadline requirement has passed, providers must submit the following to TMHP within 95 days from the add date:

- A completed claim form.
- One of the following dated within 365 days from the date of service:
  - A page from a Remittance and Status (R&S) Report documenting a denial of the claim.
  - An electronic rejection report of the claim that includes the Medicaid recipient's name and date of service.

Providers that have submitted their claims electronically can provide proof of timely filing by submitting a copy of an electronic claims report that includes the following information:

- Batch submission ID and date.
- Individual claim that is being appealed.
- TMHP-assigned batch ID number.

Note: *Only reports that were accepted or rejected by TMHP will be honored.*

6.1.3.2 Exceptions to the 95-Day Filing Deadline

TMHP is not responsible for appeals about exceptions to the 95-day filing deadline. These appeals must be submitted to the HHSC Claims Administrator Contract Management. TAC allows HHSC to consider exceptions to the 95-day filing deadline under special circumstances.

HHSC Claims Administrator Contract Management makes the final decision about whether claims fall within one of the exceptions to the 95-day filing deadline. Only providers can submit exception requests. Requests from billing companies, vendors, or clearinghouses are not accepted unless accompanied by a signed authorization from the provider (with each appeal). Without provider authorization, these requests are returned without further action.

HHSC will only consider exceptions to the 95-day filing deadline for claims that were submitted within the 365-day federal filing deadline from the date of service as outlined in 1 TAC §354.1003. The provider must submit an affidavit or statement and any additional information identifying details of cause for the delay, the exception being requested, and verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent. The person who knows the facts must make the affidavit or statement.

HHSC Claims Administrator Contract Management determines if the claim falls within one of the following exceptions:

5) Catastrophic event that substantially interferes with normal business operations of the provider, or damage or destruction of the provider's business office or records by a natural disaster, including but not limited to fire, flood, or earthquake; or damage or destruction of the provider's business office or records by circumstances that are clearly beyond the provider's control including, but not limited to, criminal activity. The damage or destruction of business records or criminal activity exception does not apply to any negligent or intentional act of an employee or agent of the provider because these people are presumed to be within the provider's control. The presumption can be rebutted only when the intentional acts of the employee or agent leads to termination of employment and filing of criminal charges against the employee or agent.

   Providers requesting an exception based on exception (1) must submit independent evidence of insurable loss claims; medical, accident, or death records; or police or fire report substantiating the exception of damage, destruction, or criminal activity.

6) Delay or error in the eligibility determination of a client or delay because of erroneous written information from the department, another state agency, or health insuring agent.

   Providers requesting an exception based on exception (2) must submit the written document from HHSC or its designee that contains the erroneous information or explanation of the delayed information.

7) Delay because of electronic claim or system implementation problems.

   Providers requesting an exception based on exception (3) must submit the written repair statement, invoice, computer or modem-generated error report (indicating attempts to transmit the data failed for reasons outside the control of the provider), or the explanation for the system implementation problems. The documentation must include a detailed explanation made by the person making the repairs or installing the system specifically indicating the relationship and impact of the computer problem or system implementation to claims submission, and a detailed statement explaining why alternative billing procedures were not initiated after the delay in repairs or system implementation was known.

8) Submission of claims occurred within the 365-day federal filing deadline but the claim was not filed within 95 days from the date of service because the service was determined to be a benefit of the Medicaid program, and an effective date for the new benefit was applied retroactively.

   Providers requesting an exception based on exception (4) must submit a written, detailed explanation of the facts and documentation to demonstrate the 365-day federal filing deadline for the benefit was met.

9) Client eligibility is determined retroactively and the provider is not notified of retroactive coverage.

   Providers requesting an exception based on exception (5) must include a written, detailed explanation of the facts and activities illustrating the provider's efforts in requesting eligibility information for the client. The explanation must contain dates, contact information, and any responses from the client.

Exception requests must be submitted in writing to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
PO Box 204077
Austin, TX 78720-4077

6.1.3.3 Appeal Time Limits

All appeals of denied claims and requests for adjustments on paid claims must be received by TMHP within 120 days from the date of disposition, the date of the R&S Report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline will be extended to the next business day.

Refer to: Subsection 6.1.2, "Claims Filing Instructions" in this section.

Hospitals appealing final technical denials, admission denials, DRG changes, continued-stay denials, or cost/day outlier denials refer to Section 7, Appeals (*Vol. 1, General Information*) for complete appeal information.

6.1.3.4 Claims with Incomplete Information and Zero Paid Claims

Claims listed on the R&S Report with $0 allowed and $0 paid may be resubmitted as electronic appeals. Previously, these claims were only accepted as paper claims and were not accepted as electronic appeals. Appeals may be submitted through a third-party biller or through TexMedConnect.

Zero-paid claims that are still within the 95-day filing deadline should be submitted as new day claims, which process faster than appeals. Claims can be resubmitted past the 95-day deadline as new day claims if the following fields have not changed:

- Provider identifiers
- Client Medicaid number
- Dates of service

- Total billed amount

All other appeal guidelines remain unchanged.

6.1.3.5 Claims Filing Reminders

After filing a claim to TMHP, providers should review the weekly R&S Report. If within 30 days the claim does not appear in the *Claims In Process* section, or if it does not appear as a paid, denied, or incomplete claim, the provider should resubmit it to TMHP within 95 days from the DOS.

The provider should allow TMHP 45 days to receive a Medicare-paid claim automatically transmitted for payment of deductible, coinsurance, or both.

Electronic billers notify TMHP about missing claims when:

- An accepted claim does not appear on the R&S Report within ten workdays of the file submittal.
- A claim or file does not appear on a TMHP Electronic Claims Submission Report within ten days of the file submission.

Certain claims, including those that were submitted for newborn services or that might be covered under Medicare, are suspended for review so that other state agencies can verify information. This review may take longer than 60 days.

These suspended claims will appear on the provider's R&S Report under "The following claims are being processed" with a message indicating that the client's eligibility is being investigated. Providers must wait until the claim is finalized and appears under "Paid or Denied" or "Adjustment to Claims" on the R&S Report before appealing the claim. If the claim does not appear on the R&S Report, providers must resubmit the claim to TMHP to ensure compliance with filing and appeal deadlines.

6.1.4 HHSC Payment Deadline

Payment deadline rules, as defined by HHSC, affect all providers with the exception of LTC and Family Planning Titles V, X, and XX.

The new HHSC payment deadline rules for the fiscal agent arrangement ensure that state and federal financial requirements are met. TMHP is required to finalize and pay claims within a determined time frame (see table below), based on provider, claim, or eligibility type.

The following table describes the new payment deadline rules:

Type	Description
All Providers	Medicaid/CSHCN payments, excluding crossovers, cannot be made after 24 months from each DOS on the claim (discharge date for inpatient claims.)
Refugee Clients	The payable period for all refugee Medicaid payments is the federal fiscal year (October-September) in which each DOS (discharge date for inpatient claims) occurs plus 1 additional federal fiscal year.
Medicaid Crossover Claims	The crossover file create date is the date in which the file is received by Medicaid. The state has 24 months from the create date to pay the crossover claim. For paper submissions, the state has 24 months from the Medicare disposition date to pay a crossover claim.
Retroactive SSI Eligibility (clients)	The payment deadline is derived from the client's eligibility "add date"; to allow 24 months from the add date for the retroactive Supplemental Security Income (SSI)-eligible client.
County Indigent SSI Eligibility (clients)	The payment deadline is derived from the client's eligibility add date; to allow 24 months from the add date to pay the claim.

Claims and appeals submitted after the designated payment deadlines are denied.

Note: *Providers may appeal HHSC Office of Inspector General (OIG) initiated claims adjustments (recoupments) after the 24-month deadline but must do so within 120 days from the date of the recoupment. Refer to subsection 7.1.4, "Paper Appeals" in Section 7, "Appeals"* (Vol. 1, General Information) *for instructions. All appeals of OIG recoupments must be submitted by paper, no electronic or telephone appeals will be accepted.*

6.1.4.1 Filing Deadline Calendar for 2010

Note: *If the 95th or 120th day falls on a weekend or holiday, the filing or appeal deadline is extended to the next business day.*

Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days
01/01 (001)	**04/06** (096)	**05/03** (123)	**03/16** (075)	**06/21** (172)	**07/14** (195)	**05/29** (149)	**09/01** (244)	**09/27** (270)	**08/11** (223)	**11/15** (319)	**12/09** (343)	**10/24** (297)	**01/27** (027)	**02/22** (053)
01/02 (002)	**04/07** (097)	**05/03** (123)	**03/17** (076)	**06/21** (172)	**07/15** (196)	**05/30** (150)	**09/02** (245)	**09/27** (270)	**08/12** (224)	**11/15** (319)	**12/10** (344)	**10/25** (298)	**01/28** (028)	**02/22** (053)
01/03 (003)	**04/08** (098)	**05/03** (123)	**03/18** (077)	**06/21** (172)	**07/16** (197)	**05/31** (151)	**09/03** (246)	**09/28** (271)	**08/13** (225)	**11/16** (320)	**12/13** (347)	**10/26** (299)	**01/31** (031)	**02/23** (054)
01/04 (004)	**04/09** (099)	**05/04** (124)	**03/19** (078)	**06/22** (173)	**07/19** (200)	**06/01** (152)	**09/06** (249)	**09/29** (272)	**08/14** (226)	**11/17** (321)	**12/13** (347)	**10/27** (300)	**01/31** (031)	**02/24** (055)
01/05 (005)	**04/12** (102)	**05/05** (125)	**03/20** (079)	**06/23** (174)	**07/19** (200)	**06/02** (153)	**09/06** (249)	**09/30** (273)	**08/15** (227)	**11/18** (322)	**12/13** (347)	**10/28** (301)	**01/31** (031)	**02/25** (056)
01/06 (006)	**04/12** (102)	**05/06** (126)	**03/21** (080)	**06/24** (175)	**07/19** (200)	**06/03** (154)	**09/06** (249)	**10/01** (274)	**08/16** (228)	**11/19** (323)	**12/14** (348)	**10/29** (302)	**02/01** (032)	**02/28** (059)
01/07 (007)	**04/12** (102)	**05/07** (127)	**03/22** (081)	**06/25** (176)	**07/20** (201)	**06/04** (155)	**09/08** (251)	**10/04** (277)	**08/17** (229)	**11/22** (326)	**12/15** (349)	**10/30** (303)	**02/02** (033)	**02/28** (059)
01/08 (008)	**04/13** (103)	**05/10** (130)	**03/23** (082)	**06/28** (179)	**07/21** (202)	**06/05** (156)	**09/08** (251)	**10/04** (277)	**08/18** (230)	**11/22** (326)	**12/16** (350)	**10/31** (304)	**02/03** (034)	**02/28** (059)
01/09 (009)	**04/14** (104)	**05/10** (130)	**03/24** (083)	**06/28** (179)	**07/22** (203)	**06/06** (157)	**09/09** (252)	**10/04** (277)	**08/19** (231)	**11/22** (326)	**12/17** (351)	**11/01** (305)	**02/04** (035)	**03/01** (060)
01/10 (010)	**04/15** (105)	**05/10** (130)	**03/25** (084)	**06/28** (179)	**07/23** (204)	**06/07** (158)	**09/10** (253)	**10/05** (278)	**08/20** (232)	**11/23** (327)	**12/20** (354)	**11/02** (306)	**02/07** (038)	**03/02** (061)
01/11 (011)	**04/16** (106)	**05/11** (131)	**03/26** (085)	**06/29** (180)	**07/26** (207)	**06/08** (159)	**09/13** (256)	**10/06** (279)	**08/21** (233)	**11/24** (328)	**12/20** (354)	**11/03** (307)	**02/07** (038)	**03/03** (062)
01/12 (012)	**04/19** (109)	**05/12** (132)	**03/27** (086)	**06/30** (181)	**07/26** (207)	**06/09** (160)	**09/13** (256)	**10/07** (280)	**08/22** (234)	**11/29** (333)	**12/20** (354)	**11/04** (308)	**02/07** (038)	**03/04** (063)
01/13 (013)	**04/19** (109)	**05/13** (133)	**03/28** (087)	**07/01** (182)	**07/26** (207)	**06/10** (161)	**09/13** (256)	**10/08** (281)	**08/23** (235)	**11/29** (333)	**12/21** (355)	**11/05** (309)	**02/08** (039)	**03/07** (066)
01/14 (014)	**04/19** (109)	**05/14** (134)	**03/29** (088)	**07/02** (183)	**07/27** (208)	**06/11** (162)	**09/14** (257)	**10/12** (285)	**08/24** (236)	**11/29** (333)	**12/22** (356)	**11/06** (310)	**02/09** (040)	**03/07** (066)
01/15 (015)	**04/20** (110)	**05/17** (137)	**03/30** (089)	**07/06** (187)	**07/28** (209)	**06/12** (163)	**09/15** (258)	**10/12** (285)	**08/25** (237)	**11/29** (333)	**12/23** (357)	**11/07** (311)	**02/10** (041)	**03/07** (066)
01/16 (016)	**04/21** (111)	**05/17** (137)	**03/31** (090)	**07/06** (187)	**07/29** (210)	**06/13** (164)	**09/16** (259)	**10/12** (285)	**08/26** (238)	**11/29** (333)	**12/27** (361)	**11/08** (312)	**02/11** (042)	**03/08** (067)
01/17 (017)	**04/22** (112)	**05/17** (137)	**04/01** (091)	**07/06** (187)	**07/30** (211)	**06/14** (165)	**09/17** (260)	**10/12** (285)	**08/27** (239)	**11/30** (334)	**12/27** (361)	**11/09** (313)	**02/14** (045)	**03/09** (068)
01/18 (018)	**04/23** (113)	**05/18** (138)	**04/02** (092)	**07/06** (187)	**08/02** (214)	**06/15** (166)	**09/20** (263)	**10/13** (286)	**08/28** (240)	**12/01** (335)	**12/27** (361)	**11/10** (314)	**02/14** (045)	**03/10** (069)
01/19 (019)	**04/26** (116)	**05/19** (139)	**04/03** (093)	**07/07** (188)	**08/02** (214)	**06/16** (167)	**09/20** (263)	**10/14** (287)	**08/29** (241)	**12/02** (336)	**12/27** (361)	**11/11** (315)	**02/14** (045)	**03/11** (070)
01/20 (020)	**04/26** (116)	**05/20** (140)	**04/04** (094)	**07/08** (189)	**08/02** (214)	**06/17** (168)	**09/20** (263)	**10/15** (288)	**08/30** (242)	**12/03** (337)	**12/28** (362)	**11/12** (316)	**02/15** (046)	**03/14** (073)
01/21 (021)	**04/26** (116)	**05/21** (141)	**04/05** (095)	**07/09** (190)	**08/03** (215)	**06/18** (169)	**09/21** (264)	**10/18** (291)	**08/31** (243)	**12/06** (340)	**12/29** (363)	**11/13** (317)	**02/16** (047)	**03/14** (073)
01/22 (022)	**04/27** (117)	**05/24** (144)	**04/06** (096)	**07/12** (193)	**08/04** (216)	**06/19** (170)	**09/22** (265)	**10/18** (291)	**09/01** (244)	**12/06** (340)	**12/30** (364)	**11/14** (318)	**02/17** (048)	**03/14** (073)
01/23 (023)	**04/28** (118)	**05/24** (144)	**04/07** (097)	**07/12** (193)	**08/05** (217)	**06/20** (171)	**09/23** (266)	**10/18** (291)	**09/02** (245)	**12/06** (340)	**01/03** (003)	**11/15** (319)	**02/18** (049)	**03/15** (074)
01/24 (024)	**04/29** (119)	**05/24** (144)	**04/08** (098)	**07/12** (193)	**08/06** (218)	**06/21** (172)	**09/24** (267)	**10/19** (292)	**09/03** (246)	**12/07** (341)	**01/03** (003)	**11/16** (320)	**02/22** (053)	**03/16** (075)
01/25 (025)	**04/30** (120)	**05/25** (145)	**04/09** (099)	**07/13** (194)	**08/09** (221)	**06/22** (173)	**09/27** (270)	**10/20** (293)	**09/04** (247)	**12/08** (342)	**01/03** (003)	**11/17** (321)	**02/22** (053)	**03/17** (076)
01/26 (026)	**05/03** (123)	**05/26** (146)	**04/10** (100)	**07/14** (195)	**08/09** (221)	**06/23** (174)	**09/27** (270)	**10/21** (294)	**09/05** (248)	**12/09** (343)	**01/03** (003)	**11/18** (322)	**02/22** (053)	**03/18** (077)
01/27 (027)	**05/03** (123)	**05/27** (147)	**04/11** (101)	**07/15** (196)	**08/09** (221)	**06/24** (175)	**09/27** (270)	**10/22** (295)	**09/06** (249)	**12/10** (344)	**01/04** (004)	**11/19** (323)	**02/22** (053)	**03/21** (080)
01/28 (028)	**05/03** (123)	**05/28** (148)	**04/12** (102)	**07/16** (197)	**08/10** (222)	**06/25** (176)	**09/28** (271)	**10/25** (298)	**09/07** (250)	**12/13** (347)	**01/05** (005)	**11/20** (324)	**02/23** (054)	**03/21** (080)
01/29 (029)	**05/04** (124)	**06/01** (152)	**04/13** (103)	**07/19** (200)	**08/11** (223)	**06/26** (177)	**09/29** (272)	**10/25** (298)	**09/08** (251)	**12/13** (347)	**01/06** (006)	**11/21** (325)	**02/24** (055)	**03/21** (080)
01/30 (030)	**05/05** (125)	**06/01** (152)	**04/14** (104)	**07/19** (200)	**08/12** (224)	**06/27** (178)	**09/30** (273)	**10/25** (298)	**09/09** (252)	**12/13** (347)	**01/07** (007)	**11/22** (326)	**02/25** (056)	**03/22** (081)
01/31 (031)	**05/06** (126)	**06/01** (152)	**04/15** (105)	**07/19** (200)	**08/13** (225)	**06/28** (179)	**10/01** (274)	**10/26** (299)	**09/10** (253)	**12/14** (348)	**01/10** (010)	**11/23** (327)	**02/28** (059)	**03/23** (082)
02/01 (032)	**05/07** (127)	**06/01** (152)	**04/16** (106)	**07/20** (201)	**08/16** (228)	**06/29** (180)	**10/04** (277)	**10/27** (300)	**09/11** (254)	**12/15** (349)	**01/10** (010)	**11/24** (328)	**02/28** (059)	**03/24** (083)
02/02 (033)	**05/10** (130)	**06/02** (153)	**04/17** (107)	**07/21** (202)	**08/16** (228)	**06/30** (181)	**10/04** (277)	**10/28** (301)	**09/12** (255)	**12/16** (350)	**01/10** (010)	**11/25** (329)	**02/28** (059)	**03/25** (084)
02/03 (034)	**05/10** (130)	**06/03** (154)	**04/18** (108)	**07/22** (203)	**08/16** (228)	**07/01** (182)	**10/04** (277)	**10/29** (302)	**09/13** (256)	**12/17** (351)	**01/11** (011)	**11/26** (330)	**03/01** (060)	**03/28** (087)
02/04 (035)	**05/10** (130)	**06/04** (155)	**04/19** (109)	**07/23** (204)	**08/17** (229)	**07/02** (183)	**10/05** (278)	**11/01** (305)	**09/14** (257)	**12/20** (354)	**01/12** (012)	**11/27** (331)	**03/02** (061)	**03/28** (087)
02/05 (036)	**05/11** (131)	**06/07** (158)	**04/20** (110)	**07/26** (207)	**08/18** (230)	**07/03** (184)	**10/06** (279)	**11/01** (305)	**09/15** (258)	**12/20** (354)	**01/13** (013)	**11/28** (332)	**03/03** (062)	**03/28** (087)
02/06 (037)	**05/12** (132)	**06/07** (158)	**04/21** (111)	**07/26** (207)	**08/19** (231)	**07/04** (185)	**10/07** (280)	**11/01** (305)	**09/16** (259)	**12/20** (354)	**01/14** (014)	**11/29** (333)	**03/04** (063)	**03/29** (088)
02/07 (038)	**05/13** (133)	**06/07** (158)	**04/22** (112)	**07/26** (207)	**08/20** (232)	**07/05** (186)	**10/08** (281)	**11/02** (306)	**09/17** (260)	**12/21** (355)	**01/18** (018)	**11/30** (334)	**03/07** (066)	**03/30** (089)
02/08 (039)	**05/14** (134)	**06/08** (159)	**04/23** (113)	**07/27** (208)	**08/23** (235)	**07/06** (187)	**10/12** (285)	**11/03** (307)	**09/18** (261)	**12/22** (356)	**01/18** (018)	**12/01** (335)	**03/07** (066)	**03/31** (090)
02/09 (040)	**05/17** (137)	**06/09** (160)	**04/24** (114)	**07/28** (209)	**08/23** (235)	**07/07** (188)	**10/12** (285)	**11/04** (308)	**09/19** (262)	**12/23** (357)	**01/18** (018)	**12/02** (336)	**03/07** (066)	**04/01** (091)
02/10 (041)	**05/17** (137)	**06/10** (161)	**04/25** (115)	**07/29** (210)	**08/23** (235)	**07/08** (189)	**10/12** (285)	**11/05** (309)	**09/20** (263)	**12/27** (361)	**01/18** (018)	**12/03** (337)	**03/08** (067)	**04/04** (094)
02/11 (042)	**05/17** (137)	**06/11** (162)	**04/26** (116)	**07/30** (211)	**08/24** (236)	**07/09** (190)	**10/12** (285)	**11/08** (312)	**09/21** (264)	**12/27** (361)	**01/19** (019)	**12/04** (338)	**03/09** (068)	**04/04** (094)
02/12 (043)	**05/18** (138)	**06/14** (165)	**04/27** (117)	**08/02** (214)	**08/25** (237)	**07/10** (191)	**10/13** (286)	**11/08** (312)	**09/22** (265)	**12/27** (361)	**01/20** (020)	**12/05** (339)	**03/10** (069)	**04/04** (094)
02/13 (044)	**05/19** (139)	**06/14** (165)	**04/28** (118)	**08/02** (214)	**08/26** (238)	**07/11** (192)	**10/14** (287)	**11/08** (312)	**09/23** (266)	**12/27** (361)	**01/21** (021)	**12/06** (340)	**03/11** (070)	**04/05** (095)
02/14 (045)	**05/20** (140)	**06/14** (165)	**04/29** (119)	**08/02** (214)	**08/27** (239)	**07/12** (193)	**10/15** (288)	**11/09** (313)	**09/24** (267)	**12/28** (362)	**01/24** (024)	**12/07** (341)	**03/14** (073)	**04/06** (096)
02/15 (046)	**05/21** (141)	**06/15** (166)	**04/30** (120)	**08/03** (215)	**08/30** (242)	**07/13** (194)	**10/18** (291)	**11/10** (314)	**09/25** (268)	**12/29** (363)	**01/24** (024)	**12/08** (342)	**03/14** (073)	**04/07** (097)
02/16 (047)	**05/24** (144)	**06/16** (167)	**05/01** (121)	**08/04** (216)	**08/30** (242)	**07/14** (195)	**10/18** (291)	**11/12** (316)	**09/26** (269)	**12/30** (364)	**01/24** (024)	**12/09** (343)	**03/14** (073)	**04/08** (098)
02/17 (048)	**05/24** (144)	**06/17** (168)	**05/02** (122)	**08/05** (217)	**08/30** (242)	**07/15** (196)	**10/18** (291)	**11/12** (316)	**09/27** (270)	**01/03** (003)	**01/25** (025)	**12/10** (344)	**03/15** (074)	**04/11** (101)
02/18 (049)	**05/24** (144)	**06/18** (169)	**05/03** (123)	**08/06** (218)	**08/31** (243)	**07/16** (197)	**10/19** (292)	**11/15** (319)	**09/28** (271)	**01/03** (003)	**01/26** (026)	**12/11** (345)	**03/16** (075)	**04/11** (101)
02/19 (050)	**05/25** (145)	**06/21** (172)	**05/04** (124)	**08/09** (221)	**09/01** (244)	**07/17** (198)	**10/20** (293)	**11/15** (319)	**09/29** (272)	**01/03** (003)	**01/27** (027)	**12/12** (346)	**03/17** (076)	**04/11** (101)
02/20 (051)	**05/26** (146)	**06/21** (172)	**05/05** (125)	**08/09** (221)	**09/02** (245)	**07/18** (199)	**10/21** (294)	**11/15** (319)	**09/30** (273)	**01/03** (003)	**01/28** (028)	**12/13** (347)	**03/18** (077)	**04/12** (102)
02/21 (052)	**05/27** (147)	**06/21** (172)	**05/06** (126)	**08/09** (221)	**09/03** (246)	**07/19** (200)	**10/22** (295)	**11/16** (320)	**10/01** (274)	**01/04** (004)	**01/31** (031)	**12/14** (348)	**03/21** (080)	**04/13** (103)
02/22 (053)	**05/28** (148)	**06/22** (173)	**05/07** (127)	**08/10** (222)	**09/06** (249)	**07/20** (201)	**10/25** (298)	**11/17** (321)	**10/02** (275)	**01/05** (005)	**01/31** (031)	**12/15** (349)	**03/21** (080)	**04/14** (104)
02/23 (054)	**06/01** (152)	**06/23** (174)	**05/08** (128)	**08/11** (223)	**09/06** (249)	**07/21** (202)	**10/25** (298)	**11/18** (322)	**10/03** (276)	**01/06** (006)	**01/31** (031)	**12/16** (350)	**03/21** (080)	**04/15** (105)
02/24 (055)	**06/01** (152)	**06/24** (175)	**05/09** (129)	**08/12** (224)	**09/06** (249)	**07/22** (203)	**10/25** (298)	**11/19** (323)	**10/04** (277)	**01/07** (007)	**02/01** (032)	**12/17** (351)	**03/22** (081)	**04/18** (108)
02/25 (056)	**06/01** (152)	**06/25** (176)	**05/10** (130)	**08/13** (225)	**09/08** (251)	**07/23** (204)	**10/26** (299)	**11/22** (326)	**10/05** (278)	**01/10** (010)	**02/02** (033)	**12/18** (352)	**03/23** (082)	**04/18** (108)
02/26 (057)	**06/01** (152)	**06/28** (179)	**05/11** (131)	**08/16** (228)	**09/08** (251)	**07/24** (205)	**10/27** (300)	**11/22** (326)	**10/06** (279)	**01/10** (010)	**02/03** (034)	**12/19** (353)	**03/24** (083)	**04/18** (108)
02/27 (058)	**06/02** (153)	**06/28** (179)	**05/12** (132)	**08/16** (228)	**09/09** (252)	**07/25** (206)	**10/28** (301)	**11/22** (326)	**10/07** (280)	**01/10** (010)	**02/04** (035)	**12/20** (354)	**03/25** (084)	**04/19** (109)
02/28 (059)	**06/03** (154)	**06/28** (179)	**05/13** (133)	**08/16** (228)	**09/10** (253)	**07/26** (207)	**10/29** (302)	**11/23** (327)	**10/08** (281)	**01/11** (011)	**02/07** (038)	**12/21** (355)	**03/28** (087)	**04/20** (110)
03/01 (060)	**06/04** (155)	**06/29** (180)	**05/14** (134)	**08/17** (229)	**09/13** (256)	**07/27** (208)	**11/01** (305)	**11/24** (328)	**10/09** (282)	**01/12** (012)	**02/07** (038)	**12/22** (356)	**03/28** (087)	**04/21** (111)
03/02 (061)	**06/07** (158)	**06/30** (181)	**05/15** (135)	**08/18** (230)	**09/13** (256)	**07/28** (209)	**11/01** (305)	**11/29** (333)	**10/10** (283)	**01/13** (013)	**02/07** (038)	**12/23** (357)	**03/28** (087)	**04/22** (112)
03/03 (062)	**06/07** (158)	**07/01** (182)	**05/16** (136)	**08/19** (231)	**09/13** (256)	**07/29** (210)	**11/01** (305)	**11/29** (333)	**10/11** (284)	**01/14** (014)	**02/08** (039)	**12/24** (358)	**03/29** (088)	**04/25** (115)
03/04 (063)	**06/07** (158)	**07/02** (183)	**05/17** (137)	**08/20** (232)	**09/14** (257)	**07/30** (211)	**11/02** (306)	**11/29** (333)	**10/12** (285)	**01/18** (018)	**02/09** (040)	**12/25** (359)	**03/30** (089)	**04/25** (115)
03/05 (064)	**06/08** (159)	**07/06** (187)	**05/18** (138)	**08/23** (235)	**09/15** (258)	**07/31** (212)	**11/03** (307)	**11/29** (333)	**10/13** (286)	**01/18** (018)	**02/10** (041)	**12/26** (360)	**03/31** (090)	**04/25** (115)
03/06 (065)	**06/09** (160)	**07/06** (187)	**05/19** (139)	**08/23** (235)	**09/16** (259)	**08/01** (213)	**11/04** (308)	**11/29** (333)	**10/14** (287)	**01/18** (018)	**02/11** (042)	**12/27** (361)	**04/01** (091)	**04/26** (116)
03/07 (066)	**06/10** (161)	**07/06** (187)	**05/20** (140)	**08/23** (235)	**09/17** (260)	**08/02** (214)	**11/05** (309)	**11/30** (334)	**10/15** (288)	**01/18** (018)	**02/14** (045)	**12/28** (362)	**04/04** (094)	**04/27** (117)
03/08 (067)	**06/11** (162)	**07/06** (187)	**05/21** (141)	**08/24** (236)	**09/20** (263)	**08/03** (215)	**11/08** (312)	**12/01** (335)	**10/16** (289)	**01/19** (019)	**02/14** (045)	**12/29** (363)	**04/04** (094)	**04/28** (118)
03/09 (068)	**06/14** (165)	**07/07** (188)	**05/22** (142)	**08/25** (237)	**09/20** (263)	**08/04** (216)	**11/08** (312)	**12/02** (336)	**10/17** (290)	**01/20** (020)	**02/14** (045)	**12/30** (364)	**04/04** (094)	**04/29** (119)
03/10 (069)	**06/14** (165)	**07/08** (189)	**05/23** (143)	**08/26** (238)	**09/20** (263)	**08/05** (217)	**11/08** (312)	**12/03** (337)	**10/18** (291)	**01/21** (021)	**02/15** (046)	**12/31** (365)	**04/05** (095)	**05/02** (122)
03/11 (070)	**06/14** (165)	**07/09** (190)	**05/24** (144)	**08/27** (239)	**09/21** (264)	**08/06** (218)	**11/09** (313)	**12/06** (340)	**10/19** (292)	**01/24** (024)	**02/16** (047)	**01/01** (001)	**04/06** (096)	**05/02** (122)
03/12 (071)	**06/15** (166)	**07/12** (193)	**05/25** (145)	**08/30** (242)	**09/22** (265)	**08/07** (219)	**11/10** (314)	**12/06** (340)	**10/20** (293)	**01/24** (024)	**02/17** (048)			
03/13 (072)	**06/16** (167)	**07/12** (193)	**05/26** (146)	**08/30** (242)	**09/23** (266)	**08/08** (220)	**11/12** (316)	**12/06** (340)	**10/21** (294)	**01/24** (024)	**02/18** (049)			
03/14 (073)	**06/17** (168)	**07/12** (193)	**05/27** (147)	**08/30** (242)	**09/24** (267)	**08/09** (221)	**11/12** (316)	**12/07** (341)	**10/22** (295)	**01/25** (025)	**02/22** (053)			
03/15 (074)	**06/18** (169)	**07/13** (194)	**05/28** (148)	**08/31** (243)	**09/27** (270)	**08/10** (222)	**11/15** (319)	**12/08** (342)	**10/23** (296)	**01/26** (026)	**02/22** (053)			

6.1.4.2 Filing Deadline Calendar for 2011

Note: *If the 95th or 120th day falls on a weekend or holiday, the filing or appeal deadline is extended to the next business day*

Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days
01/01 (001)	**04/06** (096)	**05/01** (121)	**03/16** (075)	**06/20** (171)	**07/14** (195)	**05/29** (149)	**09/01** (244)	**09/26** (269)	**08/11** (223)	**11/14** (318)	**12/09** (343)	**10/24** (297)	**01/27** (027)	**02/21** (052)
01/02 (002)	**04/07** (097)	**05/02** (122)	**03/17** (076)	**06/20** (171)	**07/15** (196)	**05/30** (150)	**09/02** (245)	**09/27** (270)	**08/12** (224)	**11/15** (319)	**12/12** (346)	**10/25** (298)	**01/30** (030)	**02/22** (053)
01/03 (003)	**04/08** (098)	**05/03** (123)	**03/18** (077)	**06/21** (172)	**07/18** (199)	**05/31** (151)	**09/06** (249)	**09/28** (271)	**08/13** (225)	**11/16** (320)	**12/12** (346)	**10/26** (299)	**01/30** (030)	**02/23** (054)
01/04 (004)	**04/11** (101)	**05/04** (124)	**03/19** (078)	**06/22** (173)	**07/18** (199)	**06/01** (152)	**09/06** (249)	**09/29** (272)	**08/14** (226)	**11/17** (321)	**12/12** (346)	**10/27** (300)	**01/30** (030)	**02/24** (055)
01/05 (005)	**04/11** (101)	**05/05** (125)	**03/20** (079)	**06/23** (174)	**07/18** (199)	**06/02** (153)	**09/06** (249)	**09/30** (273)	**08/15** (227)	**11/18** (322)	**12/13** (347)	**10/28** (301)	**01/31** (031)	**02/27** (058)
01/06 (006)	**04/11** (101)	**05/06** (126)	**03/21** (080)	**06/24** (175)	**07/19** (200)	**06/03** (154)	**09/06** (249)	**10/03** (276)	**08/16** (228)	**11/21** (325)	**12/14** (348)	**10/29** (302)	**02/01** (032)	**02/27** (058)
01/07 (007)	**04/12** (102)	**05/09** (129)	**03/22** (081)	**06/27** (178)	**07/20** (201)	**06/04** (155)	**09/07** (250)	**10/03** (276)	**08/17** (229)	**11/21** (325)	**12/15** (349)	**10/30** (303)	**02/02** (033)	**02/27** (058)
01/08 (008)	**04/13** (103)	**05/09** (129)	**03/23** (082)	**06/27** (178)	**07/21** (202)	**06/05** (156)	**09/08** (251)	**10/03** (276)	**08/18** (230)	**11/21** (325)	**12/16** (350)	**10/31** (304)	**02/03** (034)	**02/28** (059)
01/09 (009)	**04/14** (104)	**05/09** (129)	**03/24** (083)	**06/27** (178)	**07/22** (203)	**06/06** (157)	**09/09** (252)	**10/04** (277)	**08/19** (231)	**11/22** (326)	**12/19** (353)	**11/01** (305)	**02/06** (037)	**02/29** (060)
01/10 (010)	**04/15** (105)	**05/10** (130)	**03/25** (084)	**06/28** (179)	**07/25** (206)	**06/07** (158)	**09/12** (255)	**10/05** (278)	**08/20** (232)	**11/23** (327)	**12/19** (353)	**11/02** (306)	**02/06** (037)	**03/01** (061)
01/11 (011)	**04/18** (108)	**05/11** (131)	**03/26** (085)	**06/29** (180)	**07/25** (206)	**06/08** (159)	**09/12** (255)	**10/06** (279)	**08/21** (233)	**11/28** (332)	**12/19** (353)	**11/03** (307)	**02/06** (037)	**03/02** (062)
01/12 (012)	**04/18** (108)	**05/12** (132)	**03/27** (086)	**06/30** (181)	**07/25** (206)	**06/09** (160)	**09/12** (255)	**10/07** (280)	**08/22** (234)	**11/28** (332)	**12/20** (354)	**11/04** (308)	**02/07** (038)	**03/05** (065)
01/13 (013)	**04/18** (108)	**05/13** (133)	**03/28** (087)	**07/01** (182)	**07/26** (207)	**06/10** (161)	**09/13** (256)	**10/11** (284)	**08/23** (235)	**11/28** (332)	**12/21** (355)	**11/05** (309)	**02/08** (039)	**03/05** (065)
01/14 (014)	**04/19** (109)	**05/16** (136)	**03/29** (088)	**07/05** (186)	**07/27** (208)	**06/11** (162)	**09/14** (257)	**10/11** (284)	**08/24** (236)	**11/28** (332)	**12/22** (356)	**11/06** (310)	**02/09** (040)	**03/05** (065)
01/15 (015)	**04/20** (110)	**05/16** (136)	**03/30** (089)	**07/05** (186)	**07/28** (209)	**06/12** (163)	**09/15** (258)	**10/11** (284)	**08/25** (237)	**11/28** (332)	**12/23** (357)	**11/07** (311)	**02/10** (041)	**03/06** (066)
01/16 (016)	**04/21** (111)	**05/16** (136)	**03/31** (090)	**07/05** (186)	**07/29** (210)	**06/13** (164)	**09/16** (259)	**10/11** (284)	**08/26** (238)	**11/29** (333)	**12/27** (361)	**11/08** (312)	**02/13** (044)	**03/07** (067)
01/17 (017)	**04/22** (112)	**05/17** (137)	**04/01** (091)	**07/05** (186)	**08/01** (213)	**06/14** (165)	**09/19** (262)	**10/12** (285)	**08/27** (239)	**11/30** (334)	**12/27** (361)	**11/09** (313)	**02/13** (044)	**03/08** (068)
01/18 (018)	**04/25** (115)	**05/18** (138)	**04/02** (092)	**07/06** (187)	**08/01** (213)	**06/15** (166)	**09/19** (262)	**10/13** (286)	**08/28** (240)	**12/01** (335)	**12/27** (361)	**11/10** (314)	**02/13** (044)	**03/09** (069)
01/19 (019)	**04/25** (115)	**05/19** (139)	**04/03** (093)	**07/07** (188)	**08/01** (213)	**06/16** (167)	**09/19** (262)	**10/14** (287)	**08/29** (241)	**12/02** (336)	**12/27** (361)	**11/11** (315)	**02/14** (045)	**03/12** (072)
01/20 (020)	**04/25** (115)	**05/20** (140)	**04/04** (094)	**07/08** (189)	**08/02** (214)	**06/17** (168)	**09/20** (263)	**10/17** (290)	**08/30** (242)	**12/05** (339)	**12/28** (362)	**11/12** (316)	**02/15** (046)	**03/12** (072)
01/21 (021)	**04/26** (116)	**05/23** (143)	**04/05** (095)	**07/11** (192)	**08/03** (215)	**06/18** (169)	**09/21** (264)	**10/17** (290)	**08/31** (243)	**12/05** (339)	**12/29** (363)	**11/13** (317)	**02/16** (047)	**03/12** (072)
01/22 (022)	**04/27** (117)	**05/23** (143)	**04/06** (096)	**07/11** (192)	**08/04** (216)	**06/19** (170)	**09/22** (265)	**10/17** (290)	**09/01** (244)	**12/05** (339)	**12/30** (364)	**11/14** (318)	**02/17** (048)	**03/13** (073)
01/23 (023)	**04/28** (118)	**05/23** (143)	**04/07** (097)	**07/11** (192)	**08/05** (217)	**06/20** (171)	**09/23** (266)	**10/18** (291)	**09/02** (245)	**12/06** (340)	**01/03** (003)	**11/15** (319)	**02/21** (052)	**03/14** (074)
01/24 (024)	**04/29** (119)	**05/24** (144)	**04/08** (098)	**07/12** (193)	**08/08** (220)	**06/21** (172)	**09/26** (269)	**10/19** (292)	**09/03** (246)	**12/07** (341)	**01/03** (003)	**11/16** (320)	**02/21** (052)	**03/15** (075)
01/25 (025)	**05/02** (122)	**05/25** (145)	**04/09** (099)	**07/13** (194)	**08/08** (220)	**06/22** (173)	**09/26** (269)	**10/20** (293)	**09/04** (247)	**12/08** (342)	**01/03** (003)	**11/17** (321)	**02/21** (052)	**03/16** (076)
01/26 (026)	**05/02** (122)	**05/26** (146)	**04/10** (100)	**07/14** (195)	**08/08** (220)	**06/23** (174)	**09/26** (269)	**10/21** (294)	**09/05** (248)	**12/09** (343)	**01/03** (003)	**11/18** (322)	**02/21** (052)	**03/19** (079)
01/27 (027)	**05/02** (122)	**05/27** (147)	**04/11** (101)	**07/15** (196)	**08/09** (221)	**06/24** (175)	**09/27** (270)	**10/24** (297)	**09/06** (249)	**12/12** (346)	**01/04** (004)	**11/19** (323)	**02/22** (053)	**03/19** (079)
01/28 (028)	**05/03** (123)	**05/31** (151)	**04/12** (102)	**07/18** (199)	**08/10** (222)	**06/25** (176)	**09/28** (271)	**10/24** (297)	**09/07** (250)	**12/12** (346)	**01/05** (005)	**11/20** (324)	**02/23** (054)	**03/19** (079)
01/29 (029)	**05/04** (124)	**05/31** (151)	**04/13** (103)	**07/18** (199)	**08/11** (223)	**06/26** (177)	**09/29** (272)	**10/24** (297)	**09/08** (251)	**12/12** (346)	**01/06** (006)	**11/21** (325)	**02/24** (055)	**03/20** (080)
01/30 (030)	**05/05** (125)	**05/31** (151)	**04/14** (104)	**07/18** (199)	**08/12** (224)	**06/27** (178)	**09/30** (273)	**10/25** (298)	**09/09** (252)	**12/13** (347)	**01/09** (009)	**11/22** (326)	**02/27** (058)	**03/21** (081)
01/31 (031)	**05/06** (126)	**05/31** (151)	**04/15** (105)	**07/19** (200)	**08/15** (227)	**06/28** (179)	**10/03** (276)	**10/26** (299)	**09/10** (253)	**12/14** (348)	**01/09** (009)	**11/23** (327)	**02/27** (058)	**03/22** (082)
02/01 (032)	**05/09** (129)	**06/01** (152)	**04/16** (106)	**07/20** (201)	**08/15** (227)	**06/29** (180)	**10/03** (276)	**10/27** (300)	**09/11** (254)	**12/15** (349)	**01/09** (009)	**11/24** (328)	**02/27** (058)	**03/23** (083)
02/02 (033)	**05/09** (129)	**06/02** (153)	**04/17** (107)	**07/21** (202)	**08/15** (227)	**06/30** (181)	**10/03** (276)	**10/28** (301)	**09/12** (255)	**12/16** (350)	**01/10** (010)	**11/25** (329)	**02/28** (059)	**03/26** (086)
02/03 (034)	**05/09** (129)	**06/03** (154)	**04/18** (108)	**07/22** (203)	**08/16** (228)	**07/01** (182)	**10/04** (277)	**10/31** (304)	**09/13** (256)	**12/19** (353)	**01/11** (011)	**11/26** (330)	**02/29** (060)	**03/26** (086)
02/04 (035)	**05/10** (130)	**06/06** (157)	**04/19** (109)	**07/25** (206)	**08/17** (229)	**07/02** (183)	**10/05** (278)	**10/31** (304)	**09/14** (257)	**12/19** (353)	**01/12** (012)	**11/27** (331)	**03/01** (061)	**03/26** (086)
02/05 (036)	**05/11** (131)	**06/06** (157)	**04/20** (110)	**07/25** (206)	**08/18** (230)	**07/03** (184)	**10/06** (279)	**10/31** (304)	**09/15** (258)	**12/19** (353)	**01/13** (013)	**11/28** (332)	**03/02** (062)	**03/27** (087)
02/06 (037)	**05/12** (132)	**06/06** (157)	**04/21** (111)	**07/25** (206)	**08/19** (231)	**07/04** (185)	**10/07** (280)	**11/01** (305)	**09/16** (259)	**12/20** (354)	**01/17** (017)	**11/29** (333)	**03/05** (065)	**03/28** (088)
02/07 (038)	**05/13** (133)	**06/07** (158)	**04/22** (112)	**07/26** (207)	**08/22** (234)	**07/05** (186)	**10/11** (284)	**11/02** (306)	**09/17** (260)	**12/21** (355)	**01/17** (017)	**11/30** (334)	**03/05** (065)	**03/29** (089)
02/08 (039)	**05/16** (136)	**06/08** (159)	**04/23** (113)	**07/27** (208)	**08/22** (234)	**07/06** (187)	**10/11** (284)	**11/03** (307)	**09/18** (261)	**12/22** (356)	**01/17** (017)	**12/01** (335)	**03/05** (065)	**03/30** (090)
02/09 (040)	**05/16** (136)	**06/09** (160)	**04/24** (114)	**07/28** (209)	**08/22** (234)	**07/07** (188)	**10/11** (284)	**11/04** (308)	**09/19** (262)	**12/23** (357)	**01/17** (017)	**12/02** (336)	**03/06** (066)	**04/02** (093)
02/10 (041)	**05/16** (136)	**06/10** (161)	**04/25** (115)	**07/29** (210)	**08/23** (235)	**07/08** (189)	**10/11** (284)	**11/07** (311)	**09/20** (263)	**12/27** (361)	**01/18** (018)	**12/03** (337)	**03/07** (067)	**04/02** (093)
02/11 (042)	**05/17** (137)	**06/13** (164)	**04/26** (116)	**08/01** (213)	**08/24** (236)	**07/09** (190)	**10/12** (285)	**11/07** (311)	**09/21** (264)	**12/27** (361)	**01/19** (019)	**12/04** (338)	**03/08** (068)	**04/02** (093)
02/12 (043)	**05/18** (138)	**06/13** (164)	**04/27** (117)	**08/01** (213)	**08/25** (237)	**07/10** (191)	**10/13** (286)	**11/07** (311)	**09/22** (265)	**12/27** (361)	**01/20** (020)	**12/05** (339)	**03/09** (069)	**04/03** (094)
02/13 (044)	**05/19** (139)	**06/13** (164)	**04/28** (118)	**08/01** (213)	**08/26** (238)	**07/11** (192)	**10/14** (287)	**11/08** (312)	**09/23** (266)	**12/27** (361)	**01/23** (023)	**12/06** (340)	**03/12** (072)	**04/04** (095)
02/14 (045)	**05/20** (140)	**06/14** (165)	**04/29** (119)	**08/02** (214)	**08/29** (241)	**07/12** (193)	**10/17** (290)	**11/09** (313)	**09/24** (267)	**12/28** (362)	**01/23** (023)	**12/07** (341)	**03/12** (072)	**04/05** (096)
02/15 (046)	**05/23** (143)	**06/15** (166)	**04/30** (120)	**08/03** (215)	**08/29** (241)	**07/13** (194)	**10/17** (290)	**11/10** (314)	**09/25** (268)	**12/29** (363)	**01/23** (023)	**12/08** (342)	**03/12** (072)	**04/06** (097)
02/16 (047)	**05/23** (143)	**06/16** (167)	**05/01** (121)	**08/04** (216)	**08/29** (241)	**07/14** (195)	**10/17** (290)	**11/14** (318)	**09/26** (269)	**12/30** (364)	**01/24** (024)	**12/09** (343)	**03/13** (073)	**04/09** (100)
02/17 (048)	**05/23** (143)	**06/17** (168)	**05/02** (122)	**08/05** (217)	**08/30** (242)	**07/15** (196)	**10/18** (291)	**11/14** (318)	**09/27** (270)	**01/03** (003)	**01/25** (025)	**12/10** (344)	**03/14** (074)	**04/09** (100)
02/18 (049)	**05/24** (144)	**06/20** (171)	**05/03** (123)	**08/08** (220)	**08/31** (243)	**07/16** (197)	**10/19** (292)	**11/14** (318)	**09/28** (271)	**01/03** (003)	**01/26** (026)	**12/11** (345)	**03/15** (075)	**04/09** (100)
02/19 (050)	**05/25** (145)	**06/20** (171)	**05/04** (124)	**08/08** (220)	**09/01** (244)	**07/17** (198)	**10/20** (293)	**11/14** (318)	**09/29** (272)	**01/03** (003)	**01/27** (027)	**12/12** (346)	**03/16** (076)	**04/10** (101)
02/20 (051)	**05/26** (146)	**06/20** (171)	**05/05** (125)	**08/08** (220)	**09/02** (245)	**07/18** (199)	**10/21** (294)	**11/15** (319)	**09/30** (273)	**01/03** (003)	**01/30** (030)	**12/13** (347)	**03/19** (079)	**04/11** (102)
02/21 (052)	**05/27** (147)	**06/21** (172)	**05/06** (126)	**08/09** (221)	**09/06** (249)	**07/19** (200)	**10/24** (297)	**11/16** (320)	**10/01** (274)	**01/04** (004)	**01/30** (030)	**12/14** (348)	**03/19** (079)	**04/12** (103)
02/22 (053)	**05/31** (151)	**06/22** (173)	**05/07** (127)	**08/10** (222)	**09/06** (249)	**07/20** (201)	**10/24** (297)	**11/17** (321)	**10/02** (275)	**01/05** (005)	**01/30** (030)	**12/15** (349)	**03/19** (079)	**04/13** (104)
02/23 (054)	**05/31** (151)	**06/23** (174)	**05/08** (128)	**08/11** (223)	**09/06** (249)	**07/21** (202)	**10/24** (297)	**11/18** (322)	**10/03** (276)	**01/06** (006)	**01/31** (031)	**12/16** (350)	**03/20** (080)	**04/16** (107)
02/24 (055)	**05/31** (151)	**06/24** (175)	**05/09** (129)	**08/12** (224)	**09/06** (249)	**07/22** (203)	**10/25** (298)	**11/21** (325)	**10/04** (277)	**01/09** (009)	**02/01** (032)	**12/17** (351)	**03/21** (081)	**04/16** (107)
02/25 (056)	**05/31** (151)	**06/27** (178)	**05/10** (130)	**08/15** (227)	**09/07** (250)	**07/23** (204)	**10/26** (299)	**11/21** (325)	**10/05** (278)	**01/09** (009)	**02/02** (033)	**12/18** (352)	**03/22** (082)	**04/16** (107)
02/26 (057)	**06/01** (152)	**06/27** (178)	**05/11** (131)	**08/15** (227)	**09/08** (251)	**07/24** (205)	**10/27** (300)	**11/21** (325)	**10/06** (279)	**01/09** (009)	**02/03** (034)	**12/19** (353)	**03/23** (083)	**04/17** (108)
02/27 (058)	**06/02** (153)	**06/27** (178)	**05/12** (132)	**08/15** (227)	**09/09** (252)	**07/25** (206)	**10/28** (301)	**11/22** (326)	**10/07** (280)	**01/10** (010)	**02/06** (037)	**12/20** (354)	**03/26** (086)	**04/18** (109)
02/28 (059)	**06/03** (154)	**06/28** (179)	**05/13** (133)	**08/16** (228)	**09/12** (255)	**07/26** (207)	**10/31** (304)	**11/23** (327)	**10/08** (281)	**01/11** (011)	**02/06** (037)	**12/21** (355)	**03/26** (086)	**04/19** (110)
03/01 (060)	**06/06** (157)	**06/29** (180)	**05/14** (134)	**08/17** (229)	**09/12** (255)	**07/27** (208)	**10/31** (304)	**11/28** (332)	**10/09** (282)	**01/12** (012)	**02/06** (037)	**12/22** (356)	**03/26** (086)	**04/20** (111)
03/02 (061)	**06/06** (157)	**06/30** (181)	**05/15** (135)	**08/18** (230)	**09/12** (255)	**07/28** (209)	**10/31** (304)	**11/28** (332)	**10/10** (283)	**01/13** (013)	**02/07** (038)	**12/23** (357)	**03/27** (087)	**04/23** (114)
03/03 (062)	**06/06** (157)	**07/01** (182)	**05/16** (136)	**08/19** (231)	**09/13** (256)	**07/29** (210)	**11/01** (305)	**11/28** (332)	**10/11** (284)	**01/17** (017)	**02/08** (039)	**12/24** (358)	**03/28** (088)	**04/23** (114)
03/04 (063)	**06/07** (158)	**07/05** (186)	**05/17** (137)	**08/22** (234)	**09/14** (257)	**07/30** (211)	**11/02** (306)	**11/28** (332)	**10/12** (285)	**01/17** (017)	**02/09** (040)	**12/25** (359)	**03/29** (089)	**04/23** (114)
03/05 (064)	**06/08** (159)	**07/05** (186)	**05/18** (138)	**08/22** (234)	**09/15** (258)	**07/31** (212)	**11/03** (307)	**11/28** (332)	**10/13** (286)	**01/17** (017)	**02/10** (041)	**12/26** (360)	**03/30** (090)	**04/24** (115)
03/06 (065)	**06/09** (160)	**07/05** (186)	**05/19** (139)	**08/22** (234)	**09/16** (259)	**08/01** (213)	**11/04** (308)	**11/29** (333)	**10/14** (287)	**01/17** (017)	**02/13** (044)	**12/27** (361)	**04/02** (093)	**04/25** (116)
03/07 (066)	**06/10** (161)	**07/05** (186)	**05/20** (140)	**08/23** (235)	**09/19** (262)	**08/02** (214)	**11/07** (311)	**11/30** (334)	**10/15** (288)	**01/18** (018)	**02/13** (044)	**12/28** (362)	**04/02** (093)	**04/26** (117)
03/08 (067)	**06/13** (164)	**07/06** (187)	**05/21** (141)	**08/24** (236)	**09/19** (262)	**08/03** (215)	**11/07** (311)	**12/01** (335)	**10/16** (289)	**01/19** (019)	**02/13** (044)	**12/29** (363)	**04/02** (093)	**04/27** (118)
03/09 (068)	**06/13** (164)	**07/07** (188)	**05/22** (142)	**08/25** (237)	**09/19** (262)	**08/04** (216)	**11/07** (311)	**12/02** (336)	**10/17** (290)	**01/20** (020)	**02/14** (045)	**12/30** (364)	**04/03** (094)	**04/30** (121)
03/10 (069)	**06/13** (164)	**07/08** (189)	**05/23** (143)	**08/26** (238)	**09/20** (263)	**08/05** (217)	**11/08** (312)	**12/05** (339)	**10/18** (291)	**01/23** (023)	**02/15** (046)	**12/31** (365)	**04/04** (095)	**04/30** (121)
03/11 (070)	**06/14** (165)	**07/11** (192)	**05/24** (144)	**08/29** (241)	**09/21** (264)	**08/06** (218)	**11/09** (313)	**12/05** (339)	**10/19** (292)	**01/23** (023)	**02/16** (047)	**01/01** (001)	**04/05** (096)	**04/30** (121)
03/12 (071)	**06/15** (166)	**07/11** (192)	**05/25** (145)	**08/29** (241)	**09/22** (265)	**08/07** (219)	**11/10** (314)	**12/05** (339)	**10/20** (293)	**01/23** (023)	**02/17** (048)			
03/13 (072)	**06/16** (167)	**07/11** (192)	**05/26** (146)	**08/29** (241)	**09/23** (266)	**08/08** (220)	**11/14** (318)	**12/06** (340)	**10/21** (294)	**01/24** (024)	**02/21** (052)			
03/14 (073)	**06/17** (168)	**07/12** (193)	**05/27** (147)	**08/30** (242)	**09/26** (269)	**08/09** (221)	**11/14** (318)	**12/07** (341)	**10/22** (295)	**01/25** (025)	**02/21** (052)			
03/15 (074)	**06/20** (171)	**07/13** (194)	**05/28** (148)	**08/31** (243)	**09/26** (269)	**08/10** (222)	**11/14** (318)	**12/08** (342)	**10/23** (296)	**01/26** (026)	**02/21** (052)			

6.2 TMHP Electronic Claims Submission

TMHP uses the HIPAA-compliant American National Standards Institute (ANSI) ASC X12 4010A file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security.

Claims may be submitted electronically to TMHP through TexMedConnect on the TMHP website at www.tmhp.com or through billing agents who interface directly with the TMHP EDI Gateway.

Providers must retain all claim and file transmission records. They may be required to submit them for pending research on missing claims or appeals.

Refer to: Section 3, TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*).

6.2.1 Benefit and Taxonomy Codes

Providers that submit electronic claims are required to submit new data fields. The Benefit Code field (when applicable), Address field, and Taxonomy Code field must be completed before submitting electronic claims.

Taxonomy codes do not affect pricing or the level of pricing, but rather are used to crosswalk the NPI to a TPI. It is critical that the taxonomy code selected as the primary or secondary taxonomy code during a providers enrollment with TMHP is included on all electronic transactions.

Group billing providers are not required to submit a taxonomy code on all electronic claims.

Billing providers that are not associated with a group are required to submitting a taxonomy code on all electronic claims. TMHP will reject claims for non-group billing providers (individuals and facilities) that are submitted without a taxonomy code.

Medicare does not require a taxonomy code for Part B claims. Therefore, some claims submitted to TMHP from Medicare for payment of coinsurance and deductible may not include the taxonomy code needed for accurate processing by TMHP.

6.2.2 Electronic Claim Acceptance

Providers should verify that their electronic claims were accepted by Texas Medicaid for payment consideration by referring to their Claim Response report, which is in the 27S batch response file (e.g., file name E085LDS1.27S). Providers should also check their Accepted and Rejected reports in the rej and acc batch response files (e.g., E085LDS1.REJ and E085LDS1.ACC) for additional information. Only claims that have been accepted on the Claim Response report (27S file) will be considered for payment and made available for claim status inquiry. Claims that are rejected must be corrected and resubmitted for payment consideration.

Refer to: Subsection 3.2, "Electronic Billing" in Section 3, TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*), visit www.tmhp.com, or call the EDI Help Desk at 1-888-863-3638 for more information on electronic claims submissions.

6.2.3 Electronic Rejections

The most common reasons for electronic professional claim rejections are:

- *Client information does not match.* Client information does not match the patient control number (PCN) on the TMHP eligibility file. The name, date of birth, sex, and nine-digit Medicaid identification number must be an exact match with the client's identification number on TMHP's eligibility record. If using TexMedConnect, send an interactive eligibility request to obtain an exact match with TMHP's record. If not using TexMedConnect, verify through the TMHP website or call AIS at 1-800-925-9126 to verify client information. A lack of complete client eligibility information causes a rejection and possibly delayed payment. To prevent delays when submitting claims electronically:
  - Always include the first and last name of the client on the claim in the appropriate fields.

- Always enter the client's complete, valid nine-digit Medicaid number. Valid Medicaid numbers begin with 1, 2, 3, 4, or 5. CSHCN client numbers begin with a 9.
- When submitting claims for newborns, use the guidelines in the following section.

- *Referring/Ordering Physician field blank or invalid.* The referring physician's NPI must be present when billing for consultations, laboratory, or radiology. Consult the software vendor for this field's location on the electronic claims entry form.
- *Performing Physician ID field blank or invalid.* When the billing provider identifier is a *group* practice, the performing provider identifier for the physician who performed the service must be entered. Consult the software vendor for this field's location on the electronic claim form.
- *Facility Provider field blank or invalid.* When place of service (POS) is anywhere other than home or office, the facility's provider identifier must be present. If the provider identifier is not known, enter the name and address of the facility. Consult the software vendor for this field's location on the electronic claims entry form.
- *Invalid Type of Service or Invalid Type of Service/Procedure code combination.* In certain cases some procedure codes will require a modifier to denote the procedure's type of service (TOS).

  Note: *The C21 claims processing system can accept only 40 characters (including spaces) in the Comments section of electronic submissions for ambulance and dental claims. If providers include more than 40 characters in that field, C21 will accept only the first 40 characters; the other characters will not be imported into C21. Providers must ensure that all of the information that is required for the claim to process appropriately is included in the first 40 characters.*

Refer to: Subsection 6.2.7, "Modifier Requirements for TOS Assignment" in this section for TMHP EDI modifier information.

6.2.3.1 Newborn Claim Hints

The following are to be used for newborns:

- If the mother's name is "Jane Jones," use "Boy Jane Jones" for a male child and "Girl Jane Jones" for a female child.
- Enter "Boy Jane" or "Girl Jane" in first name field and "Jones" in last name field. *Always* use "boy" or "girl" first and then the mother's full name. An exact match must be submitted for the claim to process.
- Do not use "NBM" for newborn male or "NBF" for newborn female.

The following are the most common reasons for electronic hospital UB-04 CMS-1450 claim rejections:

- *Admit hour outside allowable range* (such as 24 hours).
- *Billed amount blank.*
- *Health coverage ID blank or invalid.* This number *must* be the valid nine-digit Medicaid client number. *Incorrect data* includes: a number less than nine digits; PENDING; 999999999; and Unknown.
- *Referring physician information on outpatient claim is blank* when laboratory/radiology services are ordered or a surgical procedure is performed. The referring physician's NPI is required in Fields 78–79. Consult the software vendor for the location of this field on the electronic claims entry form.

Refer to: Subsection 8.6, "PCCM" in Section 8, "Managed Care" (*Vol. 1, General Information*)

6.2.4 Resubmission of TMHP EDI Rejections

Providers that receive TMHP EDI rejections may resubmit an electronic claim within 95 days of the DOS. A paper appeal may also be submitted with a copy of the rejection report within 120 days of the rejection report to meet the filing deadline. A copy of the rejection report must accompany each corrected claim that is submitted on paper.

6.2.5 TMHP EDI Batch Numbers, Julian Dates

All electronic transactions are assigned an eight-character Batch ID immediately upon receipt by the TMHP EDI Gateway. The batch ID format allows electronic submitters to determine the exact day and year that a batch was received. The batch ID format is JJJYSSS, where each character is defined as follows:

- *JJJ—Julian date.* The three J characters represent the Julian date that the file was received by the TMHP EDI Gateway. The first character (J) is displayed as a letter, where E = 0, F = 1, G = 2, and H = 3. The last two characters (JJ) are displayed as numbers. All three characters (JJJ) together represent the Julian date.
- *Y—Year.* The Y character represents the last digit of the calendar year when the TMHP EDI Gateway receives the file. For example, a "0" in this position indicates the year 2010.
- *SSSS—Sequence number.* This part of the batch ID is a unique sequence number that is EDI-assigned and does not impact determining the Julian date or year.

For example, the batch ID E080DS12 means that the TMHP EDI gateway received the file on January 8, 2010.

6.2.6 TMHP Paper Claims Submission

All paper claims must be submitted with a TPI and NPI for the billing and performing providers. All other provider fields on the claim forms require an NPI only. If an NPI and TPI are not included in the billing and performing provider fields, or if an NPI is not included on all other provider identifier fields, the claim will be denied.

6.2.7 Modifier Requirements for TOS Assignment

Modifiers for TOS assignment are *not* required for Texas Health Steps (THSteps) Dental claims (claim type 021), Inpatient Hospital claims (claim type 040), or Medicare Crossover claims (claim types 030, 031, 050). Additionally, procedures submitted by specific provider types such as genetics, eyeglass, and THSteps medical are assigned the appropriate TOS based on the provider type or specific procedure code, and will not require modifiers.

Most procedure codes do not require a modifier for TOS assignment, but modifiers *are* required for *some* services submitted on professional claims (claim type 020) and outpatient hospital claims (claim type 023). Services that *require* a modifier for TOS assignment are listed below.

6.2.7.1 Assistant Surgery

For assistant surgical procedures, use one of the following modifiers: 80, 81, 82, and AS. Using these modifiers results in TOS 8 being assigned to the procedure.

6.2.7.2 Anesthesia

For anesthesia procedures, use one of the following modifiers: AA, AD, QK, QS, QX, QY, and QZ. Using these modifiers results in TOS 7 being assigned to the procedure.

6.2.7.3 Interpretations

For interpretations or professional components of laboratory, radiology, or radiation therapy procedures, use modifier 26. Using modifier 26 results in TOS I being assigned to the procedure.

6.2.7.4 Technical Components

For technical components of laboratory, radiology, or radiation therapy procedures, use modifier TC. Using this modifier results in TOS T being assigned to the procedure.

Exception: *Outpatient hospitals do not include the TC modifier when they provide technical components of lab and radiology services. These services automatically have TOS 4 or 5 assigned and are subject to the facility's interim reimbursement rate or the clinical lab rate.*

Additionally, the following procedure codes do not require a modifier for TOS assignment and are processed automatically as a technical component with a TOS T:

Procedure Codes									
77401	77402	77403	77404	77406	77407	77408	77409	77411	77412
77413	77414	77416	77417	93005	93017	93041	93225	93226	93231
93232	93236	93721							

6.2.8 Preferred Provider Organization (PPO)

PPO discounts are not considered a part of other insurance payments. Electronic submitters must supply the PPO discount amount when submitting other insurance information; however, this information is not included in the total other insurance payment during claims processing. Paper submitters are not required to add the PPO discount to the other insurance payment.

6.3 Coding

Electronic billers must code all claims. TMHP encourages all providers to code their paper claims. Claims are processed fast and accurately if providers furnish appropriate information. By coding claims, providers ensure precise and concise representation of the services provided and are assured reimbursement based on the correct code. If providers code claims, a narrative description is not required and does not need to be included unless the code is a not an otherwise classified code.

Important: *Claims for anesthesia must have the Current Procedural Terminology (CPT) anesthesia procedure code narrative descriptions or CPT surgical codes; if these codes are not included, the claim will be denied.*

The carrier for the Texas Medicare Program has coding manuals available for physicians and suppliers with codes not available in CPT. To order a CPT Coding Manual, write to the following address:

American Medical Association
Book and Pamphlet Fulfillment
PO Box 2964
Milwaukee, WI 53201

6.3.1 Diagnosis Coding

Texas Medicaid requires providers to provide *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes on their claims. The *only* diagnosis coding structure accepted by Texas Medicaid is the ICD-9-CM. Diagnosis codes must be to the highest level of specificity available. In most cases a written description of the diagnosis is not required. ICD-9-CM evaluation and management codes are not payable as a primary diagnosis.

All V-codes are acceptable as diagnoses except the following nonspecific codes:

Diagnosis Codes									
V0381	V0382	V0389	V039	V040	V041	V042	V043	V044	V045
V046	V047	V048	V0481	V0482	V0489	V050	V051	V052	V053
V054	V058	V059	V060	V061	V062	V063	V064	V065	V066
V068	V069	V070	V071	V078	V079	V1200	V1201	V1202	V1203
V1209	V121	V122	V1260	V1261	V1269	V1270	V1271	V1272	V1279
V1300	V1321	V1329	V133	V134	V1361	V1369	V137	V138	V139
V140	V141	V142	V143	V144	V145	V146	V147	V148	V149
V1501	V1502	V1503	V1504	V1505	V1506	V1507	V1508	V1509	V1541
V1542	V156	V157	V1581	V1582	V1584	V1585	V1586	V1587	V1588
V1589	V159	V160	V161	V162	V1640	V1641	V1642	V1643	V1649
V1651	V1659	V166	V167	V168	V169	V171	V172	V173	V174
V175	V176	V177	V1781	V1789	V1859	V200	V201	V202	V210
V211	V212	V2130	V2131	V2132	V2133	V2134	V2135	V218	V219
V260	V261	V2621	V2622	V2629	V2631	V2632	V2633	V2634	V2635
V2639	V264	V2641	V2649	V2651	V2652	V268	V2681	V2689	V269
V289	V426	V4281	V4282	V4283	V4284	V4289	V4574	V4575	V4576
V4577	V4578	V4579	V4586	V460	V4611	V4612	V4613	V4614	V462
V468	V469	V4981	V4982	V4983	V4984	V4985	V4989	V499	V500
V501	V503	V5041	V5042	V5049	V508	V509	V520	V521	V522
V523	V524	V528	V529	V534	V538	V539	V570	V5721	V5722
V574	V5781	V5789	V579	V582	V5830	V5831	V5832	V585	V589
V5901	V5902	V5909	V591	V592	V593	V594	V595	V596	V5970
V5971	V5972	V5973	V5974	V598	V599	V600	V601	V602	V603
V604	V605	V606	V609	V6110	V6111	V6112	V6120	V6129	V613
V6141	V6149	V616	V617	V618	V619	V620	V621	V623	V624
V625	V626	V6281	V6282	V6283	V6284	V6289	V629	V630	V631

Diagnosis Codes									
V632	V638	V639	V650	V651	V6511	V6519	V652	V653	V6540
V658	V659	V665	V666	V667	V669	V680	V6801	V6809	V681
V682	V6881	V6889	V689	V690	V691	V692	V693	V694	V695
V698	V699	V700	V702	V703	V704	V706	V707	V708	V709
V7211	V7212	V7219	V729	V730	V731	V732	V733	V734	V735
V736	V7388	V7389	V7398	V7399	V740	V741	V742	V743	V744
V745	V746	V748	V749	V750	V751	V752	V753	V754	V755
V756	V757	V758	V759	V762	V763	V7641	V7642	V7643	V7644
V7645	V7646	V7647	V7649	V7650	V770	V771	V772	V773	V774
V775	V776	V777	V778	V780	V781	V782	V783	V788	V789
V801	V802	V803	V810	V811	V812	V813	V814	V815	V816
V8271	V8279	V8489	V8551	V8552	V8553	V8554	V860	V861	

These nonspecific codes can be used for a general description but may not be referenced to a specific procedure code. Generally, V-codes are supplementary and are used only when the client's condition cannot be classified to categories 001 through 999. The use of observation diagnosis code V717 results in claim denial with explanation of benefits (EOB) 00543, "Documentation insufficient to verify medical necessity. Resubmit the claim with signed claim copy, R&S Report copy, and complete documentation of medical necessity."

Independent laboratories, pathologists, and radiologists are not required to provide diagnosis codes unless otherwise stated in other sections of this manual.

6.3.1.1 Place of Service (POS) Coding

The POS identifies where services are performed. Indicate the POS by using the appropriate code for each service identified on the claim.

Important: *Attention ambulance providers: POS 41 and 42 are accepted by Texas Medicaid for ambulance claims processing. The two-digit origin and destination codes are still required for claims processing.*

Use the following codes for POS identification where services are performed:

POS	2-Digit Numeric Codes (Electronic Billers)	1-Digit Numeric Codes (Paper Billers)
Office	11, 15, 50, 60, 65, 71, 72	1
Home	12	2
Inpatient hospital	21, 51, 52, 55, 56, 61	3
Outpatient hospital	22, 23, 24, 62	5
Birthing center	25	7
Other location	03, 04, 05, 06, 07, 08, 26, 34, 41, 42, 53, 99	9
Skilled nursing facility, intermediate care facility, intermediate care facility for mentally retarded	31, 32, 54	4
Extended care facility (rest home, domiciliary or custodial care, nursing facility boarding home)	33	8
Independent lab	81	6
Destination of ambulance	Indicate destination using above codes	Indicate destination using above codes

Note: *Family planning and THSteps medical services performed in an RHC are billed using national POS code 72.*

6.3.2 Type of Service (TOS)

The TOS identifies the specific field or specialty of services provided.

To determine the TOS payable for each procedure code, providers may refer to the online fee lookup (OFL) or the static fee schedules, both are available on the TMHP website at www.tmhp.com.

Refer to: Subsection 6.2.7, "Modifier Requirements for TOS Assignment" in this section for TMHP EDI modifier information.

6.3.2.1 TOS Table

Important: *TOS codes are not used for claim submissions, but they do appear on R&S Reports.*

TOS	Description
0	Blood
1	Medical Services
2	Surgery
3	Consultations

TOS	Description
4	Radiology (total component)
5	Laboratory (total component)
6	Radiation Therapy (total component)
7	Anesthesia
8	Assistant surgery
9	Other (e.g., prosthetic eyewear, contacts, ambulance)
C	Home health services
D	TB clinic
E	Eyeglasses
F	Ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC)
G	Genetics
I	Professional component for radiology, laboratory, or radiation therapy
J	DME purchase new
L	DME rental
R	Hearing aid
S	THSteps medical
T	Technical component for radiology, laboratory, or radiation therapy
W	THSteps dental

6.3.3 Procedure Coding

The procedure coding system used by Texas Medicaid is called the Healthcare Common Procedure Coding System (HCPCS). HCPCS provides health-care providers and third party payers a common coding structure that is designed around a five-character numeric or alphanumeric base for all codes.

HCPCS consists of two levels of codes including the *Current Procedural Terminology* (CPT®) *Professional Edition* (Level I) and the HCPCS codes approved and released by CMS (Level II).

At the beginning of each year, TMHP applies the annual HCPCS additions, changes, and deletions that include the program and coding changes related to the annual HCPCS, Current Dental Terminology (CDT), and CPT updates. These updates ensure an up-to-date coding structure by using the latest edition of the CPT and nationally established HCPCS codes released by CMS. Scheduled updates are announced in Medicaid bi-monthly bulletins.

Most added procedure codes that are not directly replacing a discontinued procedure code must go through the rate hearing process, as required by Chapter 32 of the *Human Resources Code*, §32.0282, and Title 1 of the *Texas Administrative Code*, §355.201, which require public hearings to receive comments on Texas Medicaid payment rates. The two levels of codes are as follows:

6.3.3.1 Level I

CPT® Professional Edition:

- All numeric—consist of five digits
- Represent 80 percent of HCPCS
- Maintenance—responsibility of the AMA, which updates annually
- Updates by the AMA are coordinated with CMS before their distribution of modifications to third party payers
- Anesthesia codes from CPT

6.3.3.2 Level II

HCPCS codes:

- Approved and released by CMS
- Codes for both physician and non-physician services not contained in CPT (for example, ambulance, DME, prosthetics, and some medical codes)
- *Updating*: Responsibility of the CMS Maintenance Task Force
- All *alphanumeric* consisting of a single alpha character (A through V) followed by four numeric digits
- The single alpha character represents the following:

Alpha	Description
A	Supplies, ambulance, administrative, miscellaneous
B	Enteral and parenteral therapy
E	DME and oxygen
G	Procedures/professional (temporary)
H	Rehab and behavioral health services
J	Drugs (administered other than orally)
K	Durable Medical Equipment Regional Carriers (DMERC)
L	Orthotic and prosthetic procedures
M	Medical
P	Laboratory
Q	Temporary procedures
R	Radiology
S	Private payer
T	State Medicaid agency
V	Vision and hearing services

6.3.3.3 Rate Hearings

All of the new procedure codes are adopted in accordance with CMS effective dates. Added procedure codes that are not directly replacing a discontinued procedure code must go through the rate hearing process. Health and Human Services Commission (HHSC) conducts public rate hearings to provide an opportunity for the provider community to comment on the Medicaid proposed payment rate.

Services provided before the rates are adopted through the rate hearing process are denied as pending a rate hearing (EOB 02008) until the applicable reimbursement rate is adopted. The client cannot be billed for these services. Providers are responsible for meeting the initial 95-day filing deadline. Once the reimbursement rates are established in the rate hearing and applied, TMHP will reprocess claims, and no further action on the part of the provider is necessary.

Providers must submit the procedure codes that are most appropriate for the services provided, even if the procedure codes have not yet completed the rate hearing process and are denied by Texas Medicaid as pending a rate hearing.

Authorization guidelines for procedure codes awaiting a rate hearing are available in subsection 5.9, "Guidelines for Procedures Awaiting Rate Hearing" in Section 5, "Prior Authorization" (*Vol. 1, General Information*)..

6.3.4 National Drug Code (NDC)

The NDC is an 11-digit number on the package or container from which the medication is administered. All Texas Medicaid fee-for-service, PCCM, and Family Planning providers must submit an NDC for professional or outpatient claims submitted with physician-administered prescription drug procedure. Codes in the A code series do not require an NDC.

N4 must be entered before the NDC on claims.

The unit of measurement codes can also be submitted, however, are not required. The codes to be used for all claim forms are:

- F2 – International unit
- GR – Gram
- ML – Milliliter
- UN – Unit

Unit quantities can also be submitted, however, are not required.

Depending on the claim type, the NDC information must be submitted as indicated below for paper claims, or the equivalent electronic field:

UB-04 CMS 1450

Block No.	Description	Guidelines
43	Revenue codes and description	Enter N4 and the 11-digit NDC number (number on the package or container from which the medication was administered). **Optional:** The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to 3 digits) can also be submitted, however, are not required. Do not enter hyphens or spaces within this number. Example: N400409231231GR0.025

CMS-1500

Block No.	Description	Guidelines
24A	Dates of service	In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on the package or container from which the medication was administered). Do not enter hyphens or spaces within this number. Example: N400409231231
24D	Procedures, services, or supplies	**Optional:** In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit.
24G	Days or units	**Optional:** In the shaded area, enter the NDC unit of measurement code.

Family Planning 2017

Block No.	Description	Guidelines
32A	Dates of service	In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on the package or container from which the medication was administered). Do not enter hyphens or spaces within this number. Example: N400409231231
32D	Procedures, services, or supplies CPT/HCPCS Modifier	**Optional:** In the shaded area, enter a 1-through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit. A decimal point must be used for fractions of a unit.
32F	Days or units	**Optional:** In the shaded area, enter the NDC unit of measurement code.

The Drugs Requiring NDC for Texas Medicaid Reimbursement list is available on the TMHP website at www.tmhp.com. The list contains those physician-administered, multiple-source drugs that the U.S. Secretary of Health and Human Services has determined to have the highest dollar volume of physician-administered drugs that are dispensed through Medicaid.

6.3.5 Modifiers

Modifiers describe and qualify the services provided by Texas Medicaid. A modifier is placed after the five-digit procedure code. Up to two modifiers may apply per service. Examples of frequently used modifiers are listed in the following table. Refer to the service-specific sections for additional modifier requirements.

Modifier	Special Instructions/Notes (if applicable)
Ambulance	
ET	Use for emergency services.
GY	Use to indicate that no medical necessity existed for a transport.
Surgeons	
53	Use for physician reporting of a discontinued procedure. For outpatient/ASC reporting of a discontinued procedure, see modifier 73 and 74.
54+	Surgeons who do not provide the postoperative care for a patient *must* bill the surgery code with modifier 54. The modifier will reimburse the surgeon at 80 percent of the allowed amount.
55+	Physicians who provide only the postoperative care may bill the appropriate visit codes and *must* use modifier 55 to indicate only postoperative care services were provided. Services indicated as postoperative care only by use of this modifier will not be denied as part of the global surgical fee.
62+	Cosurgery. Two surgeons perform the specific procedure(s).
66+	Cosurgery. Two surgeons are necessary to perform the highly complex surgical procedure(s).
76+	Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.
77+	Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.
Assistant Surgeons	
80 *and* KX+	Use modifier 80 and KX together to indicate an assistant surgeon in a teaching facility: • In a case involving exceptional medical circumstances such as emergency or life-threatening situations requiring immediate attention. • When the primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of one of his or her patients. • In a case involving a complex surgical procedure that qualifies for more than one physician.
+ Modifier is required for accurate claims processing. *** Description is defined by the state.**	

Modifier	Special Instructions/Notes (if applicable)
AS	Use when the physician assistant is not enrolled as an individual provider and provides assistance at surgery.
Sterilizations	
PM	Use to indicate post-menopausal.
PS	Use to indicate previously sterilized.
Excision of Lesions/Masses	
KX+	Use modifier KX if the excision/destruction is due to one of the following signs or symptoms: inflamed, infected, bleeding, irritated, growing, limiting motion or function. Use of this modifier is subject to retrospective review.
Injections	
AT	Use to indicate acute conditions.
JA	Administered intravenously.
JB	Administered subcutaneously.
KX+	Use modifier KX to indicate the injection was due to: • Oral route contraindicated or an acceptable oral equivalent is not available. • Injectable medication is the accepted treatment of choice. Oral medication regimens have proven ineffective or are not available. • Patient has a temperature over 102 degrees (documented on the claim) and a high level of antibiotic is needed quickly. • Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare up of a chronic condition.
Visits	
52+	Use with normal newborn care if the service did not comprise a THSteps screen.
76+	Use to indicate the repeated non-clinical procedure.
FP+	Use to indicate that the service was part of an annual family planning examination.
TH+	Use with evaluation and management procedures to specify antepartum or postpartum care.
25	Use to describe circumstances in which an office visit was provided at the same time as other separately identifiable services.
Anesthesia	
One of the following modifiers must be used by physicians in conjunction with the CPT code for anesthesia services:	

+ Modifier is required for accurate claims processing.

*** Description is defined by the state.**

Modifier	Special Instructions/Notes (if applicable)
AA	Use to indicate that the services were performed personally by the anesthesiologist.
AD	Use to indicate medical supervision by a physician or more than four concurrent anesthesia procedures. Modifier is also used when a modifier is not submitted on the claim.
QK	Use to indicate medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
FQHC and RHC	
Services provided by a health-care professional require one of the following modifiers:	
AH	Use to indicate that the services were performed by a clinical psychologist.
AJ	Use to indicate that the services were performed by a clinical social worker.
AM	Use to indicate that the services were performed by a physician or team member service (includes clinical psychiatrist).
SA	Use to indicate that the services were performed by an advanced practice nurse (APN) or CNM rendering services in collaboration with a physician.
TD	For home services performed by a RN and provided in areas with a shortage of home health agencies.
TE	For home services performed by an LVN and provided in areas with a shortage of home health agencies.
U1	Licensed professional counselor
U2	Licensed marriage and family therapist
U7*	Physician assistant services for other than assistant at surgery
The following modifiers may be used in addition to the modifier identifying the health-care professional that rendered the service:	
EP	Use to indicate THSteps services (FQHC only).
FP	Use to indicate that the service was part of an annual family planning examination.
TH	Use to indicate the encounter is for antepartum care or postpartum care.
TU	For services provided outside of normal business hours to a client enrolled in the PCCM program.
U5*	State-defined modifier for use with case management services.

+ Modifier is required for accurate claims processing.
*** Description is defined by the state.**

Modifier	Special Instructions/Notes (if applicable)
Certified Registered Nurse Anesthetist (CRNA)	
One of the following modifiers must be used by CRNAs in conjunction with the CPT code for anesthesia services:	
QX	Use to indicate the anesthesia was medically directed by the anesthesiologist.
QZ	Use to indicate the anesthesia was directed by the surgeon.
Abortion	
G7	Use by performing physicians, facilities, anesthesiologists, and CRNAs (with appropriate procedure code) when requesting reimbursement for abortion procedures that are within the scope of the rules and regulations of Texas Medicaid.
Vision	
RB	Use modifier RB to indicate repair or replacement lenses or frames
VP+	Use when billing for an adult with diagnosis code 37931.
Laboratory/Radiology	
26+	Use for laboratory interpretations and radiological procedures.
91+	Use for repeat laboratory clinical test.
76	Use for repeat laboratory nonclinical test.
SU+	Indicates necessary equipment is in physician's office for RAST/MAST testing or Pap smears.
TC+	The modifier TC is used for technical radiological procedures.
Q4+	Use for lab/radiology/ultrasound interps by other than the attending physician.
Therapy	
AT+	Must be used to indicate the necessity of an acute condition for occupational therapy (OT), physical therapy (PT), osteopathic manipulation treatment (OMT), or chiropractic services.
GN	Use to indicate outpatient speech language pathology.
GO	Use to indicate outpatient occupational therapy.
GP	Use to indicate outpatient PT.
U4*	Reassessment
THSteps Medical	

+ Modifier is required for accurate claims processing.
*** Description is defined by the state.**

Modifier	Special Instructions/Notes (if applicable)
AM	Physician, team member service
EP	FQHCs must use modifier EP for services provided under THSteps.
SA	Nurse practitioner rendering service in collaboration with a physician
U7*	Physician assistant services for other than assistant at surgery
TD	Registered nurse
SC	Medically necessary service or supply
23	Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier *23* to the procedure code of the basic service or by use of the separate five-digit modifier code 09923
32	Mandated Services: Services related to mandated consultation or related services (e.g., peer review organization [PRO], third party payer, governmental, legislative or regulatory requirement) may be identified by adding the modifier 32 to the basic procedure or the service may be reported by use of the five digit modifier 09932
Physicians	
Q5	Informal reciprocal arrangement (period not to exceed 14 continuous days)
Q6	Locum tenens or temporary arrangement (up to 90 days)
Radiologists	
U6	CT, CTA, MRI, and MRA studies provided in the emergency department
Durable Medical Equipment	
NU	Use to indicate purchased equipment.
RR	Use to indicate leased equipment.
Telemedicine	
GT	Use with appropriate evaluation and management code.
AM	Use with RHC and FQHC encounter codes.
SA	Use with RHC and FQHC encounter codes.

+ Modifier is required for accurate claims processing.
*** Description is defined by the state.**

Other Common Modifiers									
AE	AF	AG	AK	AR	CB	CD	CE	CF	CG
KC	KD	KF	LT	M2	RD	RT	SW	SY	TL*
UN	UP	UQ	UR	US					

*** Must be used by providers rendering Early Childhood Intervention (ECI)-THSteps/CCP therapy and nutritional services.**

The following modifiers may appear on R&S Reports (they are not entered by the provider):

- *PT.* The DRG payment was calculated on a per diem basis for an inpatient stay because of patient transfer.
- *PS.* The DRG payment was calculated on a per diem basis because the patient exhausted the 30-day inpatient benefit limitation during the stay.
- *PE.* The DRG payment was calculated on a per diem basis because the patient was ineligible for Medicaid during part of the stay. Also used to adjudicate claims with adjustments to outlier payments.

Note: *Modifiers PT, PS, and PE will appear for DRG claims only.*

6.3.6 Benefit Code

A benefit code is an additional data element used to identify state programs.

Providers that participate in the following programs must use the associated benefit code when submitting claims and authorizations:

Program	Benefit Code
Comprehensive Care Program (CCP)	CCP
THSteps Medical	EP1
THSteps Dental	DE1
Family Planning Agencies*	FP3
Hearing Aid Dispensers	HA1
Maternity	MA1
County Indigent Health Care Program	CA1
Early Childhood Intervention (ECI) Providers	ECI
Tuberculosis (TB) Clinics	TB1
Texas Medicaid Program Home Health DME	DM2
Case management mental retardation (MR) providers	MH2

***Agencies only—Benefit codes should not be used for individual family planning providers.**

6.4 Claims Filing Instructions

This section contains instructions for completion of Medicaid-required claim forms. When filing a claim, providers should review the instructions *carefully* and complete *all* requested information. A correctly completed claim form is processed faster.

This section provides a sample claim form and its corresponding instruction table for each acceptable Texas Medicaid claim form.

All providers, except those on prepayment review, should submit paper claims to TMHP to the following address:

Texas Medicaid & Healthcare Partnership
Claims
PO Box 200555
Austin, TX 78720-0555

Providers 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
P.O. Box 203638
Austin, TX 78720-3638

6.4.1 Claim Form Requirements

When filing claims for a STAR or STAR+PLUS Program members, providers should follow the client's STAR or STAR+PLUS health plan's claim filing requirements.

6.4.1.1 Provider Signature on Claims

Each CMS-1500, 2006 American Dental Association (ADA), and Family Planning 2017 *paper claim* form submitted must have the handwritten signature (or signature stamp) of the provider or an authorized representative in the appropriate block of the claim form. Signatory supervision of the authorized representative is required. Providers delegating signature authority to a member of the office staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment. Initials are only acceptable for first and middle names. The last name must be spelled out. An acceptable example is J.A. Smith for John Adam Smith. An unacceptable example is J.A.S. for John Adam Smith. Typewritten names *must* be accompanied by a handwritten signature; in other words, a typewritten name with signed initials is *not* acceptable. The signature *must* be contained within the appropriate block of the claim form. Claims prepared by computer billing services or office-based computers may have "Signature on File" printed in the signature block, but it must be in the same font that is used in the rest of the form. For claims prepared by a billing service, the billing service must retain a letter on file from the provider authorizing the service.

Printing the provider's name instead of "Signature on File" is unacceptable. Because space is limited in the signature block, providers should not type their names in the block. Claims not meeting these specifications appear in the "Paid or Denied Claims" sections of the R&S Reports.

Refer to: "Form 6.1, "Sample Letter XUB Computer Billing Service Inc" in this handbook.

6.4.1.2 Group Providers

Providers billing as a group must give the performing provider identifier on their claims as well as the group provider identifier.

6.4.1.3 Prior Authorization Numbers on Claims

Claims filed to TMHP must contain only one prior authorization number per claim. Prior authorization numbers must be indicated on the appropriate electronic field, or on the paper claim forms as indicated below:

- CMS-1500—Block 23
- UB-04 CMS-1450—Block 63
- ADA—Block 2
- Family Planning—Block 30

6.4.1.4 Newborn Clients Without Medicaid Numbers

If a Medicaid eligible newborn has not been assigned a Medicaid number on the DOS, the provider must wait until a Medicaid client number is assigned to file the claim. The provider writes the number instead of "Pending." The 95-day filing period begins on the "add date," which is the date the eligibility is received and added to the TMHP eligibility file. Providers verify eligibility and add date through TexMedConnect or by calling AIS or the TMHP Contact Center at 1-800-925-9126 after the number is received.

Providers must check Medicaid eligibility regularly to file claims within the required 95-day filing deadline.

Refer to: Section 4, Client Eligibility (*Vol. 1, General Information*).

6.4.1.5 Multipage Claim Forms

6.4.1.5.1 Professional Claims

The approved electronic claims format is designed to list 50 line items. The total number of details allowed for a professional claim by the TMHP claims processing system (C21) is 28. If the services provided exceed 28 line items on an approved electronic claims format or 28 line items on paper claims, the provider must submit another claim for the additional line items.

The CMS-1500 paper claim form is designed to list six line items in Block 24. If more than six line items are billed on a paper claim, a provider may attach additional forms (pages) totaling no more than 28 line items. The first page of a multipage claim must contain all the required billing information. On subsequent pages of the multipage claim, the provider should identify the client's name, diagnosis, information required for services in Block 24, and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form and indicate "continued" in Block 28. The combined total charges for all pages should be listed on the last page in Block 28.

6.4.1.5.2 Institutional Claims

The total number of details allowed for an institutional claim by the TMHP claims processing system (C21) is 28. C21 merges like revenue codes together to reduce the lines to 28 or less. If the C21 merge function is unable to reduce the lines to 28 or less, the claim will be denied, and the provider will need to reduce the number of details and resubmit the claim.

An EDI approved electronic format of the UB-04 CMS-1450 is designed to list 61 lines. C21 merges like revenue codes together to reduce the lines to 28 or less.

Providers submitting electronic claims using TexMedConnect may not submit more than 28 lines. If the services exceed the 28 lines, the provider may submit another claim for the additional lines or merge codes.

The paper UB-04 CMS-1450 is designed to list 23 lines in Block 43. If services exceed the 23-line limitation, the provider may attach additional pages. The first page of a multipage claim must contain all required billing information. On subsequent pages, the provider identifies the client's name, diagnosis, all information required in Block 43, and the page number of the attachment (e.g., page 2 of 3) in the top right-hand corner of the form and indicate "continued" on Line 23 of Block 47. The combined total charges for all pages should be listed on the last page on Line 23 of Block 47.

Note: *Each surgical procedure code listed in Block 74 of the claim form is counted as one detail and is included in the 28-detail limitation.*

When splitting a claim, all pages must contain the required information. Usually, there are logical breaks to a claim. For example, the provider may submit the surgery charges in one claim and the subsequent recovery days in the next claim.

TEFRA hospitals are required to submit all charges.

6.4.1.6 Attachments to Claims

To expedite claims processing, providers must supply all information on the claim form itself and limit attachments to those required by TMHP or necessary to supply information to properly adjudicate the claim. The following claim form attachments are required when appropriate:

- All claims for services associated with an elective sterilization must have a valid Sterilization Consent Form attached or on file at TMHP.
- Nonemergency ambulance transfers must have documentation of medical necessity including out-of-locality transfers.
- Providers filing for coinsurance, deductible, or both on Medicare claims to TMHP must attach the paper MRAN received from Medicare or a Medicare intermediary, the computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services, or the TMHP Standardized MRAN form. Providers that submit paper crossover claims must submit only one of the approved MRAN formats. Paper crossover claims submitted with multiple MRAN forms (e.g., TMHP Standardized MRAN Forms and any other MRAN) with conflicting information will not be processed and will be returned to the provider. This requirement does not apply to claims transferred automatically to TMHP from the Medicare intermediary.
- Medically necessary abortions performed (on the basis of a physician's professional judgement, the life of the mother is endangered if the fetus were carried to term), or abortions provided for pregnancy related to rape or incest must have a signed and dated physician certification statement. Elective abortions are *not* benefits of Texas Medicaid.
- Hysterectomies must have a Hysterectomy Acknowledgment Statement attached or on file at TMHP.

Refer to: Form MD.4, "Hysterectomy Acknowledgment Form" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

6.4.1.7 Clients with a Designated or Primary Care Provider

Claims for clients with a primary care provider or designated provider (i.e., managed care clients or Limited Program clients) must indicate the primary care provider or designated provider identifiers in the billing or performing provider fields.

When clients receive services from a different provider, such as a specialist, the primary care provider or designated provider's information must be included in the referring provider fields on the claim.

6.5 CMS-1500 Claim Filing Instructions

The following providers bill for services using the ANSI ASC X12 837P 4010A electronic specifications or the CMS-1500 claim form:

Providers
Ambulance
ASC (freestanding)
Case Management: blind and visually impaired children (BVIC), Early Childhood Intervention (ECI), and Children and Pregnant Women (CPW)

Providers
Certified nurse-midwife (CNM)
Certified registered nurse anesthetist (CRNA)
Certified respiratory care practitioner (CRCP)
Chemical dependency treatment facilities
Chiropractor
Clinical nurse specialist (CNS)
Dentist (doctor of dentistry practicing as a limited physician)
DME or durable medical equipment–home health services (DMEH) supplier (CCP and home health services)
Family planning agency that does not also receive funds from Title V, X, or XX
FQHC
Genetic service agency
Hearing aid
In-home total parenteral nutrition (TPN) supplier
Laboratory
Licensed dietitian (CCP only)
Licensed clinical social worker (LCSW)
Licensed professional counselor (LPC)
Maternity service clinic (MSC)
Mental health (MH) rehabilitative services
Nurse practitioner (NP)
Occupational therapist (CCP only)
Optician/optometrist/opthamologist
Orthotic and prosthetic supplier (CCP only)
Physical therapist
Physician (group and individual)
Physician assistant (PA)
Tuberculosis clinic

Providers
Podiatrist
Private duty nurse (PDN) (CCP only)
Psychologist
Radiology
School Health and Related Services (SHARS)
Speech language pathologist (CCP only)
THSteps medical

Providers obtain copies of the CMS-1500 claim form from a vendor of their choice; TMHP does not supply them.

6.5.1 CMS-1500 Electronic Billing

Electronic billers must submit CMS-1500 claim forms with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 4010A format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/EDI. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: Subsection 3.2, "Electronic Billing" in Section 3, TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information about electronic billing.

6.5.2 CMS-1500 Claim Form (Paper) Billing

Claims must contain the billing provider's complete name, address, and a provider identifier. Claims without a provider name, address, and provider identifier cannot be processed. Each claim form must have the appropriate signatory evidence in the signature certification block.

Important: *When completing a CMS-1500 claim form, all required information must be included on the claim in the appropriate block. Information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.*

6.5.3 CMS-1500 Blank Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

6.5.4 CMS-1500 Instruction Table

The instructions describe what information must be entered in each of the block numbers of the CMS-1500 claim form. Block numbers *not* referenced in the table may be left blank. They are *not* required for claim processing by TMHP.

Block No.	Description	Guidelines
1a	Insured's ID No. (for program checked above, include all letters)	Enter the patient's nine-digit patient number from the Medicaid identification form.
2	Patient's name	Enter the patients last name, first name, and middle initial as printed on the Medicaid identification form. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name and before the first name.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YYYY) the patient was born. Indicate the patient's gender by checking the appropriate box. Only one box can be marked.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information such as: • If the patient is deceased, enter "DOD" in block 9 and the time of death in 9a if the services were rendered on the date of death. Enter the date of death in block 9b.
10a 10b 10c	Is patient's condition related to: 10)a. Employment (current or previous)? 11)b. Auto accident? 12)c. Other accident?	Check the appropriate box. If other insurance is available, enter appropriate information in Blocks 11, 11a, and 11b.
11 11a 11b	Other health insurance coverage	• If another insurance resource has made payment or denied a claim, enter the name of the insurance company. The other insurance EOB or denial letter must be attached to the claim form. • If the patient is enrolled in Medicare attach a copy of the Medicare Remittance Advice Notice (MRAN) to the claim form.
11c	Insurance plan or program name	Enter the benefit code, if applicable, for the billing or performing provider.

Block No.	Description	Guidelines
12	Patient's or authorized person's signature	Enter "Signature on File," "SOF", or legal signature. When legal signature is entered, enter the date signed in eight digit format (MMDDYYYY). TMHP will process the claim without the signature of the patient.
14	Date of current	Enter the first date (MM/DD/YYYY) of the present illness or injury. For pregnancy enter the date of the last menstrual period. If the patient has chronic renal disease, enter the date of onset of dialysis treatments. Indicate the date of treatments for PT and OT.

Block No.	Description	Guidelines
17 17b	Name of referring physician or other source	Enter the complete name (Block 17) and the NPI (Block 17b) of the attending, referring, ordering, designated, or performing (freestanding ASCs only) provider. Refer to specific sections for requirements. in the following situations: **The attending physician for:** • Clinical pathology consultations to hospital inpatients or outpatients • Services provided to a client in a nursing facility (skilled nursing facility [SNF], intermediate care facility [ICF], or extended care facility [ECF]) **The referring physician for:** • Services provided to managed care clients (must be the client's primary care provider). ***Note:*** *If there is not a referral from the primary care provider, a prior authorization number (PAN) must be on the claim.* • Consultation services • CCP services • Radiology services. • Radiation therapy services. **The ordering physician for:** • Laboratory and radiology services • Speech-language therapy • Physical therapy • Occupational therapy • In-home TPN services The designated provider for nonemergency services provided to limited clients on referral. The performing provider (surgeon) for freestanding ASCs**.**
19	Reserved for local use	**Transfers of multiple clients** If the claim is part of a multiple transfer, indicate the other clients complete name and Medicaid number. **Ambulance Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.

Block No.	Description	Guidelines
20	Outside lab?	Check the appropriate box. The information may be requested for retrospective review. If "yes," enter the provider identifier of the facility that performed the service in Block 32.
21	Diagnosis or nature of illness or injury	Enter up to four ICD-9-CM diagnosis codes to the highest level of specificity available.
23	Prior authorization number	Enter the PAN issued by TMHP.
24	(Various)	General notes for Blocks 24a through 24j: • Unless otherwise specified, all required information should be entered in the unshaded portion. • If more than six line items are billed for the entire claim, a provider must attach additional claim forms with no more than 28-line items for the entire claim. • For multi-page claim forms, indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the claim form.
24a	Date(s) of service	Enter the date of service for each procedure provided in a MM/DD/YYYY format. If more than one date of service is for a single procedure, each date must be given on a separate line. **NDC** In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). Do not enter hyphens or spaces within this number. **Example:** N400409231231 ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24b	Place of service	Select the appropriate POS code for each service from the table under subsection 6.3.1.1, "Place of Service (POS) Coding" in this section.
24c	EMG (THSteps medical checkup condition indicator)	Enter the appropriate condition indicator for THSteps medical checkups. ***Refer to:*** Subsection 6.5.1, "THSteps Medical Checkups" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Block No.	Description	Guidelines
24d	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes and modifier for all services billed. If a procedure code is not available, enter a concise description. **NDC** **Optional:** In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit. ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24e	Diagnosis pointer	Enter the line item reference (1, 2, 3, or 4) of each diagnosis code identified in Block 21 for each procedure. Indicate the primary diagnosis only. Do not enter more than one diagnosis code reference per procedure. This can result in denial of the service.
24f	Charges	Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients.
24g	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). **NDC** **Optional:** In the shaded area, enter the NDC unit of measurement code. ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24j	Rendering provider ID # (performing)	Enter the provider identifier of the individual rendering services unless otherwise indicated in the provider specific section of this manual. Enter the TPI in the shaded area of the field. Entered the NPI in the unshaded area of the field.
26	Patient's account number	**Optional:** Enter the patient identification number if it is different than the subscriber/insured's identification number. Used by provider's office to identify internal client account number.
27	Accept assignment	**Required** All providers of the Texas Medicaid must accept assignment to receive payment by checking **Yes**.

Block No.	Description	Guidelines
28	Total charge	Enter the total charges. For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. ***Note:*** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in Block 11. If the client makes a payment, the reason for the payment must be indicated in Block 11.
30	Balance due	If appropriate, subtract Block 29 from Block 28 and enter the balance.
31	Signature of physician or supplier	The physician, supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. ***Refer to:*** Subsection 6.4.1.1, "Provider Signature on Claims" in this section.
32	Service facility location information	If services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP code of the facility where the service was provided.
32A	NPI	Enter the NPI of the service facility location.
33	Billing provider info & PH #	Enter the billing provider's name, street, city, state, ZIP+4 code, and telephone number.
33A	NPI	Enter the NPI of the billing provider.
33B	Other ID #	Enter the TPI number of the billing provider.

6.6 UB-04 CMS-1450 Claim Filing Instructions

The following provider types may bill electronically or use the UB-04 CMS-1450 claim form when requesting payment:

Provider Types
ASCs (hospital-based)
Comprehensive outpatient rehabilitation facilities (CORFs) (CCP only)
FQHCs ***Note:*** *Must use CMS-1500 when billing THSteps.*

Provider Types
Home health agencies
Hospitals • Inpatient (acute care, rehabilitation, military, and psychiatric hospitals) • Outpatient
Renal dialysis center
RHCs (freestanding and hospital-based)

6.6.1 UB-04 CMS-1450 Electronic Billing

Electronic billers must submit UB-04 CMS-1450 claims with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837I 4010A format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, field locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: Subsection 3.2, "Electronic Billing" in Section 3, TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for more information about electronic billing.

6.6.2 UB-04 CMS-1450 Claim Form (Paper) Billing

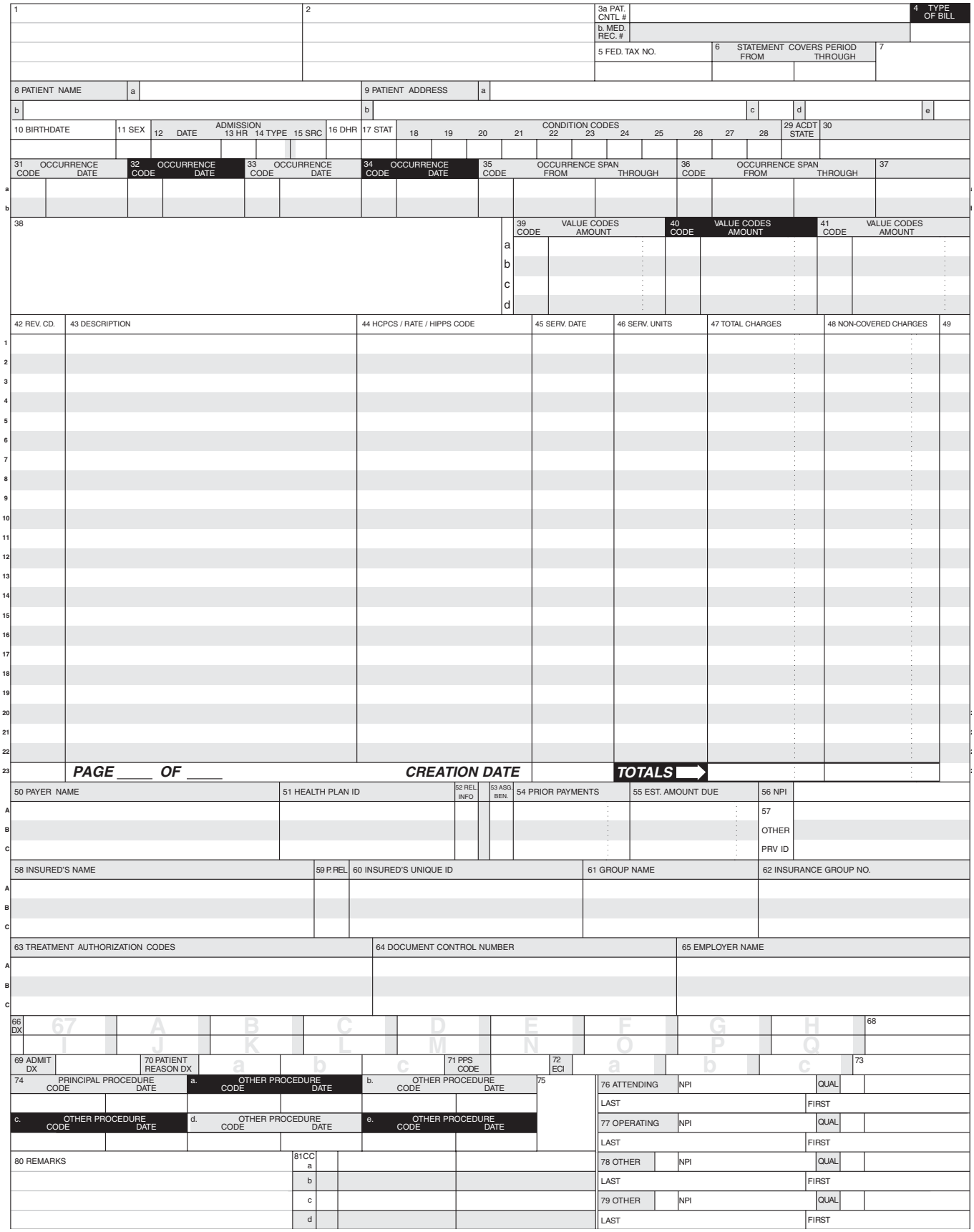
Providers obtain the UB-04 CMS-1450 paper claim forms from a vendor of their choice.

Note: *To avoid claim denial, only the provider's NPI should be placed in form locators 76-79 of the UB-04 CMS-1450 claim form or in the referring provider field on the electronic claim unless the client is a limited client.*

Completed UB-04 CMS-1450 claims must contain the billing provider's full name, address, and provider identifier. Claims *without* a provider name, address, and provider identifier *cannot* be processed.

Refer to: Subsection 6.6.4, "UB-04 CMS-1450 Instruction Table" in this section.

6.6.3 UB-04 CMS-1450 Blank Claim Form



6.6.4 UB-04 CMS-1450 Instruction Table

The instructions describe what information must be entered in each of the block numbers of the UB-04 CMS-1450 claim form. Block numbers not referenced in the table may be left blank. They are not required for claim processing by TMHP.

Block No.	Description	Guidelines
1	Unlabeled	Enter the hospital name, street, city, state, ZIP+4 Code, and telephone number.
3a	Patient control number	**Optional:** Any alphanumeric character (limit 16) entered in this block is referenced on the R&S Report.
3b	Medical record number	Enter the patient's medical record number (limited to ten digits) assigned by the hospital.
4	Type of bill (TOB)	Enter a TOB code. First Digit—Type of Facility: 1 Hospital 2 Skilled nursing 3 Home health agency 7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC], and renal dialysis center [RDC]) 8 Special facility Second Digit—Bill Classification (except clinics and special facilities): 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) 7 Intermediate care Second Digit—Bill Classification (clinics only): 1 Rural health 2 Hospital-based or independent renal dialysis center 3 Free standing 5 CORFs Third Digit—Frequency: 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim-first claim 3 Interim-continuing claim 4 Interim-last claim 5 Late charges-only claim 6 Adjustment of prior claim 7 Replacement of prior claim
6	Statement covers period	Enter the beginning and ending dates of service billed.
8a	Patient identifier	**Optional:** Enter the patient identification number if it is different than the subscriber/insured's identification number. Used by providers office to identify internal patient account number.

Block No.	Description	Guidelines
8b	Patient name	Enter the patient's last name, first name, and middle initial as printed on the Medicaid identification form.
9a–9b	Patient address	Starting in 9a, enter the patient's complete address as described (street, city, state, and ZIP+4 Code).
10	Birthdate	Enter the patient's date of birth (MM/DD/YYYY).
11	Sex	Indicate the patient's gender by entering an "M" or "F."
12	Admission date	Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; or start of care (SOC) for home health claims. Providers that receive a transfer patient from another hospital must enter the actual dates the patient was admitted into each facility.
13	Admission hour	Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims.
14	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in Block 15.) 5 Trauma center
15	Source of admission	Enter the appropriate source of admission code for inpatient claims. **For type of admission 1, 2, 3, or 5:** 1 Physician referral 2 Clinic referral 3 Health maintenance organization (HMO) referral 4 Transfer from a hospital 5 Transfer from skilled nursing facility (SNF) 6 Transfer from another health-care facility 7 Emergency room 8 Court/law enforcement 9 Information not available **For type of admission 4 (newborn):** 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available
16	Discharge hour	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the block blank.

Block No.	Description	Guidelines
17	Patient Status	For inpatient claims, enter the appropriate two-digit code to indicate the patient's status as of the statement "through" date. ***Refer to:*** Subsection 6.6.6, "Patient Status Codes" in this section.
18–28	Condition codes	Enter the two-digit condition code "05" to indicate that a legal claim was filed for recovery of funds potentially due to a patient.
29	ACDT state	**Optional:** Accident state.
31-34	Occurrence codes and dates	Enter the appropriate occurrence code(s) and date(s). Blocks 54, 61, 62, and 80 must also be completed as required. ***Refer to:*** Subsection 6.6.5, "Occurrence Codes" in this section.
35-36	Occurrence span codes and dates	For inpatient claims, enter code "71" if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay.
39-41	Value codes	Accident hour–For inpatient claims, if the patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39–41 must equal the total days billed as rejected in Block 6.
42-43	Revenue codes and description	For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate. **NDC** Enter N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). **Optional:** The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to 3 digits) can also be submitted but they are not required. Do not enter hyphens or spaces within this number. **Example**: N400409231231GR0.025 ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.

Block No.	Description	Guidelines
44	HCPCS/rates	**Inpatient:** Enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. **Home Health Services** Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. **Outpatient:** Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement. ***Note:*** *The UB-04 CMS-1450 claim form is limited to 28 items per outpatient claim. This limitation includes surgical procedures from Blocks 74 and 74a-e.* *If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims.*
45	Service date	Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims.
45 (line 23)	Creation date	Enter the date the bill was submitted.
46	Serv. units	Provide units of service, if applicable. For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in this block should always represent hours spent in observation.
47	Total charges	Enter the total charges for each service provided.
47 (line 23)	Totals	Enter the total charges for the entire claim. ***Note:*** *For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
48	Noncovered charges	If any of the total charges are noncovered, enter this amount.

Block No.	Description	Guidelines
50	Payer Name	Enter the health plan name.
51	Health Plan ID	Enter the health plan identification number.
54	Prior payments	Enter amounts paid by any TPR, and complete Blocks 32, 61, 62, and 80 as required.
56	NPI	Enter the NPI of the billing provider.
57	Other identification (ID) number	Enter the TPI number (non-NPI number) of the billing provider.
58	Insured's name	If other health insurance is involved, enter the insured's name.
60	Medicaid identification number	Enter the patient's nine-digit Medicaid identification number.
61	Insured group name	Enter the name and address of the other health insurance.
62	Insurance group number	Enter the policy number or group number of the other health insurance.
63	Treatment authorization code	Enter the prior authorization number if one was issued.
65	Employer name	Enter the name of the patient's employer if health care might be provided.
67	Principal diagnosis (DX) code and present on admission (POA) indicator	Enter the ICD-9-CM diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available. **Optional:** POA Indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.
67A-67Q	Other DX codes and POA indicator	Enter the ICD-9-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block, using Blocks A through J only. A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB "141"). **Exception**: A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alphafetoprotein. ***Note:*** *ICD-9-CM diagnosis codes entered in 67K–67Q are not required for systematic claims processing.* **Optional:** POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.
69	Admit DX code	Enter the ICD-9-CM diagnosis code indicating the cause of admission or include a narrative ***Note:*** *The admitting diagnosis is only for inpatient claims.*

Block No.	Description	Guidelines
70a-70c	Patient's reason DX	**Optional:** New block indicating the patient's reason for visit on unscheduled outpatient claims.
71	Prospective Payment System (PPS) code	**Optional:** The PPS code is assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72a-72c	External cause of injury (ECI) and POA indication	**Optional:** Enter the ICD-9-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.
74	Principal procedure code and date	Enter the ICD-9-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
74a-74e	Other procedure codes and dates	Enter the ICD-9-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
76	Attending provider	Enter the attending provider name and identifiers. NPI number of the attending provider. Services that required an attending provider are defined as those listed in the ICD-9-CM coding manual volume 3, which includes surgical, diagnostic, or medical procedures.
77	Operating	Enter operating provider's name (last name and first name) and NPI number of the operating provider.
78-79	Other	Other provider's name (last name and first name) and NPI. Other operating physician—An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved. Rendering provider—The health-care professional who performed, delivered, or completed a particular medical service or nonsurgical procedure ***Note:*** *If the referring physician is a resident, Blocks 76 through 79 must identify the physician who is supervising the resident.*

Block No.	Description	Guidelines
80	Remarks	This block is used to explain special situations such as the following: • The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this block. • If a patient stays beyond dismissal time, indicate the medical reason if additional charge is made. • If billing for a private room, the medical necessity must be indicated, signed, and dated by the physician. • If services are the result of an accident, the cause and location of the accident must be entered in this block. The time must be entered in Block 39. • If laboratory work is sent out, the name and address or the provider identifier of the facility where the work was forwarded must be entered in this block. • If the patient is deceased, enter the date of death and indicate "DOD". If services were rendered on the date of death, enter the time of death. • If the services resulted from a family planning provider's referral, write "family planning referral." • If services were provided at another facility, indicate the name and address of the facility where the services were rendered. • Request for 110-day rule for a third party insurance.
81A-81D	Code code (CC)	**Optional:** Area to capture additional information necessary to adjudicate the claims. required when, in the judgment of the provider, the information is needed to substantiate the medical treatment and is not support elsewhere on the claim data set.

6.6.5 Occurrence Codes

Code	Description	Guidelines
01	Auto accident/auto liability insurance involved	Enter the date of an auto accident. Use this code to report an auto accident that involves auto liability insurance requiring proof of fault.
02	Auto or other accident/ no fault involved	Enter the date of the accident including auto or other where no-fault coverage allows insurance immediate claim settlement without proof of fault. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with the no-fault insurer.

Code	Description	Guidelines
03	Accident/tort liability	Enter the date of an accident (excluding automobile) resulting from a third party's action. This incident may involve a civil court action in an attempt to require payment by the third party other than no-fault liability. ***Refer to:*** Subsection 4.11.6, "Third Party Liability - Tort" in section 4 (Vol. 1, General Information)
04	Accident/employment-related	Enter the date of an accident that allegedly relates to the patient's employment and involves compensation or employer liability. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with Workers' Compensation insurance or an employer. Only services not covered by Workers' Compensation may be considered for payment by Medicaid.
05	Other accident	Enter the date of an accident not described by the above codes. Use this code to report no other casualty related payers have been determined.
06	Crime victim	Enter the date on which a medical condition resulted from alleged criminal action.
10	Last menstrual period	Enter the date of the last menstrual period when the service is maternity-related.
11	Onset of symptoms	Indicate the date the patient first became aware of the symptoms or illness being treated.
16	Date of last therapy	Indicate the last day of therapy services for OT, PT, or speech therapy (ST).
17	Date outpatient OT plan established or last reviewed	Indicate the date a plan was established or last reviewed for occupation therapy.
24	Date other insurance denied	Enter the date of denial of coverage by a TPR.
25	Date benefits terminated by primary payer	Enter the last date for which benefits are being claimed.
27	Date home health plan of treatment was established	Enter the date the current plan of treatment was established.
29	Date outpatient PT plan established or last reviewed	Indicate the date a plan of treatment was established or last reviewed for physical therapy.
30	Date outpatient speech pathology plan established or last reviewed	Indicate the date a plan of treatment for speech pathology was established or last reviewed.

Code	Description	Guidelines
35	Date treatment started for PT	Indicate the date services were initiated for physical therapy.
44	Date treatment started for OT	Indicate when occupational therapy services were initiated.
45	Date treatment started for speech-language pathology (SLP)	Indicate when speech language pathology services were initiated.
50	Date other insurance paid	Indicate the date the other insurance paid the claim.
51	Date claim filed with other insurance	Indicate the date the claim was file to the other insurance.
52	Date renal dialysis initiated	Indicate the date the renal dialysis is initiated.

6.6.6 Patient Status Codes

Code	Description
01	Routine Discharge
02	Discharged to another short-term general hospital
03	Discharged to SNF
04	Discharged to ICF
05	Discharged to another type of institution
06	Discharged to care of home health service organization
07	Left against medical advice
08	Discharged/transferred to home under care of a Home IV provider
09	Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)
20	Expired or did not recover
30	Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG)
40	Expired at home (hospice use only)
41	Expired in a medical facility (hospice use only)
42	Expired—place unknown (hospice use only)

Code	Description
43	Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital)
50	Hospice—Home
51	Hospice—Medical Facility
61	Discharged/ Transferred within this institution to a hospital-based Medicare-approved swing bed
62	Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital
63	Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH)
64	Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a critical access hospital (CAH)

6.6.7 Filing Tips for Outpatient Claims

The following are outpatient claim filing tips:

- Use HCPCS codes in Block 44 when available and give a narrative description in Block 43 for all services and supplies provided.

Important: *Services and supplies that exceed the 28 items per claim limitation must be submitted on an additional UB-04 CMS-1450 claim form and will be assigned a different claim number by TMHP. Claims may have 61 detail lines for services and supplies plus one detail line for the total amount billed.*

- Combine central supplies and bill as one item. IV supplies may be combined and billed as one item. Include appropriate quantities and total charges for each combined procedure code used. Using combination procedure codes conserves space on the claim form.
- The 28-item limitation per claim: a UB-04 CMS-1450 claim form submitted with 28 or fewer items is given an internal control number (ICN) by TMHP. Multipage claim forms are processed as one claim for that client *if all* pages contain 28 or fewer items.
- Itemized Statements: Itemized statements are not used for assignment of procedure codes. HCPCS codes or narrative descriptions of procedures *must* be reflected on the face of the UB-04 CMS-1450 claim form. Attachments will only be used for clarification purposes.
- PT/OT procedures are based on time (initial 30 minutes or additional 15 minutes). Use the quantity billed to reflect the number of additional 15-minute increments.

Line Item	Description	Quantity
Example: one hour of PT service should be billed as two line items.		
#1	Therapeutic exercise	1

Line Item	Description	Quantity
#2	Additional 15 minutes	2

Refer to: Subsection 6.3.3, "Procedure Coding" in this section.

6.7 2006 American Dental Association (ADA) Dental Claim Filing Instructions

Providers billing for dental services and Intermediate Care Facility for Persons with Mental Retardation (ICF-MR) dental services may bill electronically or use the 2006 ADA claim form.

Note: *TMHP is responsible for reimbursing all THSteps dental services provided by dentists, including services rendered to STAR and STAR+PLUS clients.*

6.7.1 2006 ADA Dental Claim Electronic Billing

Electronic billers must submit THSteps dental claims using TexMedConnect or an approved vendor software that uses the ANSI ASC X12 837D 4010A format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, block locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: Section 3, TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for more information about electronic filing.

6.7.2 ADA Dental Claim Form (Paper) Billing

All participating THSteps dental providers are required to submit a 2006 ADA Dental claim form for paper claim submissions to Texas Medicaid. These forms may be obtained by contacting the ADA at 1-800-947-4746.

Claims must contain the billing provider's complete name, address and a provider identifier. Claims without a provider name, address, and provider identifier cannot be processed.

6.7.3 2006 ADA Dental Claim Form

A sample of the ADA Dental Claim form can be found on the ADA website at www.ada.org/prof/resources/topics/claimform.asp.

6.7.4 2006 ADA Dental Claim Form Instruction Table

The following table is an itemized description of the questions appearing on the form. Thoroughly complete the 2006 ADA Dental claim form according to the instructions in the table to facilitate prompt and accurate reimbursement and reduce follow-up inquiries.

ADA Block No.	ADA Description	Instructions
1	Type of Transaction	For Texas Medicaid, check the Statement of Actual Services Box. The other two boxes are not applicable. Do not use the 2006 ADA Dental Claim Form as a Texas Medicaid Program Prior Authorization form. ***Refer to:*** "THSteps Dental Mandatory Prior Authorization Request Form" on page B-111.

ADA Block No.	ADA Description	Instructions
2	Predetermination/Pre authorization Number	Enter prior authorization number if assigned by Medicaid.
3	Company/Plan Name, Address, City, State, ZIP Code	Enter TMHP and the address. ***Refer to:*** "Written Communication With TMHP" on page XX.
4	Other Dental or Medical Coverage?	Check No if no other dental or medical coverage (skip Blocks 5-11). Check Yes if dental or medical coverage is available other than Texas Medicaid coverage, and complete Blocks 5-11.
5-11	Other Coverage Information	General notes: • Enter the information for non-Medicaid insurance coverage. • Enter the information for the policyholder or subscriber, not necessarily the patient. May be a parent or legal guardian of the patient receiving treatment.
5	Name of Policy-holder/Subscriber in # 4	Enter the policyholder/subscriber name.
6	Date of Birth (MM/DD/CCYY)	Enter policyholder/subscriber eight-digit date of birth (MM/DD/YYYY).
7	Gender	Check the appropriate box for the policyholder/subscriber gender
8	Policy-holder/Subscriber ID	Enter policyholder/subscriber identifier.
9	Plan/Group Number	Enter policyholder/subscriber plan/group number.
10	Patient's Relationship to Person Named in # 5	Enter the patient's relationship to policyholder/subscriber.
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code	Enter the contact information for the insurance company providing the non-Medicaid coverage.
12	Policy-holder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Enter the Medicaid patient's last name, first name, and middle initial as printed on the Medicaid identification form.

ADA Block No.	ADA Description	Instructions
13	Date of Birth (MM/DD/CCYY)	Enter the Medicaid patient's date of birth (MM/DD/YYYY).
14	Gender	Check the appropriate box for the Medicaid patient's gender.
15	Policy-holder/Subscriber ID	Enter nine-digit patient number from the Medicaid identification form.
16	Plan/Group/Number	Enter the billing or performing provider's benefit code, if applicable.
17	Employer Name	Not applicable to Texas Medicaid.
18	Relationship to Policy-holder/Subscriber in # 12 Above	Not applicable to Texas Medicaid.
19	Student Status	Not applicable to Texas Medicaid. For exceptions to periodicity refer to Block 35.
20	Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Not applicable to Texas Medicaid.
21	Date of Birth (MM/DD/CCYY)	Not applicable to Texas Medicaid.
22	Gender	Not applicable to Texas Medicaid.
23	Patient ID/Account # (Assigned by Dentist)	**Optional**: Enter the patient identification number if it is different than the subscriber/insured's identification number. Used by dental office to identify internal patient account number.
24	Procedure Date (MM/DD/CCYY)	Enter the eight-digit date of service (MM/DD/YYYY).
25	Area of Oral Cavity	Not applicable to Texas Medicaid.
26	Tooth System	Not applicable to Texas Medicaid.
27	Tooth Number(s) or Letter(s)	Enter the Tooth ID as required for procedure code. ***Refer to:*** "Tooth Identification (TID) and Surface Identification (SID) Systems" on page 19-10.
28	Tooth Surface	Enter Surface ID as required for procedure code. ***Refer to:*** "Tooth Identification (TID) and Surface Identification (SID) Systems" on page 19-10.

ADA Block No.	ADA Description	Instructions
29	Procedure Code	Use appropriate Current dental terminology (CDT) procedure code.
30	Description	Enter brief description for the CDT procedure code.
31	Fee	Enter usual and customary charges for each service listed. Charges must not be higher than the fees charged to private pay clients.
32	Other Fee(s)	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in Block 11. If the client makes a payment, the reason for the payment must be indicated in Block 11.
33	Total Fee	Enter the sum of all fees in Block 31. For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. ***Note:*** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
34	Place an X on each missing tooth	Place an X on the appropriate tooth number to identify each missing tooth.
35	Remarks	Use this space for:" • Explanation of exception to periodicity. • "The facility name and address if the place of treatment indicated in Block 38 is not the provider's office. • Explanation of emergency if indicated in Block 45. • To provide more information such as reports for local orthodontia codes, 999 codes, multiple supernumerary teeth, or remarks.
36	Patient/Guardian signature	Not applicable to Texas Medicaid.
37	Subscriber signature	Not applicable to Texas Medicaid.
38	Place of Treatment	Check only Provider's Office or Hospital box. Do not use ECF and Other. Check the Hospital box for services rendered in a day surgery facility.
39	Number of Enclosures	Enter the number of enclosures (attachments) accompanying the claim, if applicable. Texas Medicaid does not require radiographs with claims. **Exception:** When requested, radiographs may be submitted with appeals.

ADA Block No.	ADA Description	Instructions
40	Is Treatment for Orthodontics?	Check Yes or No as appropriate.
41	Date Appliance Placed	Not applicable to Texas Medicaid.
42	Months of Treatment Remaining	Not applicable to Texas Medicaid.
43	Replacement of Prosthesis?	Not applicable to Texas Medicaid.
44	Date Prior Placement	Not applicable to Texas Medicaid.
45	Treatment Resulting from (Check applicable box)	Providers are required to check the Other Accident box for emergency claim reimbursement. If the Other Accident box is checked, information about the emergency must be provided in Block 35.
46	Date of Accident (MM/DD/CCYY)	Not applicable to Texas Medicaid.
47	Auto Accident State	Not applicable to Texas Medicaid.
48	Name, Address, City, State, ZIP Code	Enter the name and address of the billing group or individual provider. Do not enter the name and address of a provider employed within a group.
49	NPI	Enter the billing provider's NPI for a group or an individual. Do not enter the NPI for a provider employed within a group.
50	License Number	Not applicable to Texas Medicaid.
51	Social Security Number (SSN) or Tax Identification Number (TIN)	Not applicable to Texas Medicaid.
52	Telephone Number	Enter the area code and number for the billing group or individual Do not enter the telephone number of a provider employed within a group.
52A	Additional Provider ID	Enter the nine-digit TPI assigned to the billing dentist or dental entity. Do not enter the TPI for a provider employed within a group.
53	Signed (Treating Dentist)	Required-Signature of treating dentist or authorized personnel. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. ***Refer to:*** "Provider Signature on Claims".

ADA Block No.	ADA Description	Instructions
54	NPI	Enter the NPI for the dentist enrolled as part of a group who treated the patient. Does not apply to individual providers.
55	License Number	Not applicable to Texas Medicaid.
56	Address, City, State, ZIP Code	Not applicable to Texas Medicaid.
56A	Provider Specialty Code	This block is optional.
57	Telephone Number	Not applicable to Texas Medicaid.
58	Additional Provider ID	**Required** Enter the TPI for the dentist's enrolled as part of a group who treated the patient. Does not apply to individual providers.

6.8 Family Planning Claim Filing Instructions

The following providers bill for services using the ANSI ASC X12 837P 4010A electronic specifications or the CMS-1500 paper claim form:

Providers
Clinical nurse specialist (CNS)
Family Planning title agencies contracted with DSHS
Federally Qualified Health Center (FQHC)
Nurse practitioner (NP)
Physician
Physician assistant (PA)

6.8.1 Family Planning Electronic Billing

Electronic billers must submit family planning claims with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 4010A format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/EDI. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: "Electronic Billing" (Section 3, TMHP Electronic Data Interchange, Vol. 1, General Information) for information about electronic billing.

6.9 Family Planning Claim Form (Paper Billing)

Claims must contain the billing providers complete name, address, and a provider identifier. Claims without a provider name, address, and provider identifier cannot be processed.

6.9.1 Family Planning 2017 Claim Form

Family Planning 2017 Claim Form

1. Family Planning Program: V ☐ XIX ☐ XX ☐

1a. Title X Only — Full Pay ☐ Partial Pay ☐ No Pay ☐

2a. Billing Provider TPI

2b. Billing Provider NPI

3. Provider Name

4. Eligibility Date (V or XX) (MM/DD/CCYY)

5. Family Planning No. (Medicaid PCN if XIX)

6. Patient's Name (Last Name, First Name, Middle Initial)

7. Address (Street, City, State)

7a. ZIP code

8. County of Residence

9. Date of Birth (MM/DD/CCYY)

10. Sex F ☐ M ☐

11. Patient Status — New Patient ☐ Established Patient ☐

12. Patient's Social Security Number - -

13. Race (Code #) ☐
White (1) Black (2) AmIndian/AlaskaNat (4) Asian (5)
Unk/NotRep (6) NatHawaii/PacIsland (7) More than one race (8)

13a. Ethnicity ☐
Hispanic (5) Non-Hispanic (0)

14. Marital Status ☐
(1) Married (2) Never Married (3) Formerly Married

15. Family Income (All) $

15a. Family Size

16. Number Times Pregnant

17. Number Live Births

18. Number Living Children

19. Primary Birth Control Method Before Initial Visit ☐

20. Primary Birth Control Method at End of This Visit ☐

a=Oral Contraceptive; b=1-Month hormonal injection; c=3-Month hormonal injection; d=Cervical cap/diaphragm; e=Abstinence; f= Hormonal Implant; g=Male condom; h=Female condom; i=Hormonal/Contraceptive patch; j=Spermicide (used alone); k=Intrauterine device (IUD); l=Vaginal ring; m=Fertility awareness method (FAM); n=Sterilization; o=Contraceptive sponge; p=Other method; q=Method unknown; r=No method (if used for #20, must complete #21)

21. If No Method Used at End of This Visit, Give Reason (Required only if #20 = r) ☐

a=Refused; b=Pregnant; c=Inconclusive Preg Test; d=Seeking Preg; e=Infertile; f=Rely on Partner; g=Medical

22. Is There Other Insurance Available? Y ☐ N ☐ If Y, Complete Items 23 – 25a

23. Other Insurance Name and Address

24a. Insured's Policy/Group No.

24b. Benefit Code

25. Other Insurance Pd. Amt. $

25a. Date of Notification

26. Name of Referring Provider

27a. Referring Other ID

27b. Referring NPI

28. Level of Practitioner Physician ☐ Nurse ☐ Mid Level ☐ Other ☐

29. Diagnosis Code (Relate Items 1,2,3,or 4 to Item 32D by Line # in 32E)
1. _____ 3. _____
2. _____ 4. _____

30. Authorization Number

31. Date of Occurrence (MM / DD / CCYY)

32.	A Dates of Service From MM	DD	CCYY	To MM	DD	CCYY	B Place of Service	C Type of Service	D Procedures, Services, or Supplies CPT/HCPCS	Modifier	E Dx. Ref. (29)	F Units or Days (Quantity) No. of Participants (Teen Counseling)	G $ Charges	H Performing Provider #
1														TPI
														NPI
2														TPI
														NPI
3														TPI
														NPI
4														TPI
														NPI
5														TPI
														NPI

33. Federal Tax ID Number/EIN

34. Patient's Account No. (optional)

35. Patient Co-Pay Assessed (V, X or XX) $

36. **Total Charges**

37. Signature of Physician or Supplier
Date:
Signed:

38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)

38a. NPI

38b. Other ID

39. Physician's, Supplier's Billing Name, Address, Zip Code & Phone No.

6.9.2 Family Planning 2017 Claim Form Instructions

Block No.	Description	Guidelines	Required
1	Family planning program	Check the box for the specific entitlement funds to which these family planning services are billed. If the facility also receives Title X funds, the Level of Practitioner (28) must be indicated. ***Note:*** *Claims/Encounters will be cross-checked with Title XIX Medicaid eligibility before Title V, X, or XX processing.*	V, XIX, XX
1a	Title X only	If it is a "Title X Only" encounter, the level of payment must be indicated. If the facility also receives Title X funds, the level of practitioner (28) must be indicated.	X
2a	Billing provider TPI	Enter the billing provider's nine-digit TPI.	V, X, XIX, XX
2b	Billing provider NPI	Enter the billing provider's NPI.	V, X, XIX, XX
3	Provider name	Enter the provider's name as enrolled with TMHP.	V, X, XIX, XX
4	Eligibility date (V or XX)	Enter the date (MM/DD/CCYY) this client was originally designated eligible for Title V or XX services. If client has V or XX eligibility from a previous visit, enter that eligibility date. For a Title XX client, this information comes from the 2025 claim form. For a Title V client, this information comes from the Texas Eligibility Screening System (TESS).	V, XX
5	Family planning no. (Medicaid PCN if XIX)	If previous V, X, or XX claims or encounters have been submitted to TMHP, enter the client's nine-digit family planning number, which begins with "F." If the client has Title XIX Medicaid, enter the client's nine-digit client number from the Medicaid Identification form. If this is a new family planning client, without Medicaid, leave this block blank and TMHP will assign a family planning number for the client.	XIX
6	Patient's name (last name, first name, middle initial)	Enter the client's last name, first name, and middle initial as printed on the Medicaid Identification Form, if Title XIX, or as printed in the provider's records, if Title V, X, or XX.	V, X, XIX, XX
7	Address (street, city, state)	Enter the client's complete home address as described by the client (street, city, and state). This reflects the location where the client lives.	V, X, XIX, XX

Block No.	Description	Guidelines	Required
7a	ZIP Code	Enter the client's ZIP Code.	V, X, XIX, XX
8	County of residence	Enter the county code that corresponds to the client's address. Please use the HHSC county codes.	V, X, XIX, XX
9	Date of birth	Enter numerically the month, day, and year (MM/DD/CCYY) the client was born.	V, X, XIX, XX
10	Sex	Indicate the client's gender by checking the appropriate box.	V, X, XIX, XX
11	Patient status	Indicate if this is the client's first visit to this family planning provider (new patient) or if this client has been to this family planning provider previously (established patient). If the provider's records have been purged and the client appears to be new to the provider, check "New Patient."	V, X, XIX, XX
12	Patient's Social Security number	Enter the client's nine-digit Social Security number (SSN). If the client does not have a SSN, or refuses to provide the number, enter 000-00-0001.	V, X, XIX, XX
13	Race (code #)	Indicate the client's race by entering the appropriate race code number in the box. Aggregate categories used here are consistent with reporting requirements of the Office of Management and Budget Statistical Direction. Race is independent of ethnicity and all clients should be self-categorized as White, Black or African American, American Indian or Native Alaskan, Asian, Native Hawaiian or other Pacific Islander, or Unknown or Not Reported. An "Hispanic" client must also have a race category selected.	V, X, XIX, XX
13a	Ethnicity	Indicate whether the client is of Hispanic descent by entering the appropriate code number in the box. Ethnicity is independent of race and all clients should be counted as either Hispanic or non-Hispanic. The Office of Management and Budget defines Hispanic as "a person of Mexican, Puerto Rican, Cuban, Central, or South American culture or origin, regardless of race."	V, X, XIX, XX
14	Marital status	Indicate the client's marital status by entering the appropriate marital code number in the box.	V, X, XIX, XX

Block No.	Description	Guidelines	Required
15	Family income (all)	Titles V, XX, XX: Use the gross monthly income calculated and reported on the eligibility assessment tool. Title XIX providers: Enter the gross monthly income reported by the client. Be sure to include all sources of income. No documentation of income is required. For clients who are married (including common-law marriages) or who are 20 years of age or older, enter the gross monthly income of all family members. For unmarried clients age 19 years or younger, enter the gross monthly income of the client only, not the income of all family members. *To calculate gross monthly income for Title XIX:* If income is received in a lump sum, or if it is for a period of time greater than a month (e.g., for seasonal employment), divide the total income by the number of months included in the payment period. If income is paid weekly, multiply weekly income by 4.33. If paid every two weeks, multiply amount by 2.165. If paid twice a month, multiply by 2. Enter $1.00 for clients not wishing to reveal income information.	V, X, XIX, XX
15a	Family size	Titles V, X, XX: Use the family size reported on the eligibility assessment tool. Title XIX providers: Enter the number of family members supported by the income listed in Box 15. Must be at least "one."	V, X, XIX, XX
16	Number times pregnant	Enter the number of times this client has been pregnant. If male, enter zero.	V, X, XIX, XX
17	Number live births	Enter the number of live births for this client. If male, enter zero.	V, X, XIX, XX
18	Number living children	Enter the number of living children this client has. This also must be completed for male clients.	V, X, XIX, XX
19	Primary birth control method before initial visit	Enter the appropriate code letter (a through r) in the box.	V, X, XIX, XX
20	Primary birth control method at end of this visit	Enter the appropriate code letter (a through r) in the box.	V, X, XIX, XX

Block No.	Description	Guidelines	Required
21	If no method used at end of this visit, give reason (required only if #20=r)	If the primary birth control method at the end of the visit was "no method" (r), you must complete this box with an appropriate code letter from this block (a through g).	V, X, XIX, XX (only if #20=r)
22	Is there other insurance available?	Check the appropriate box.	
23	Other insurance name and address	Enter the name and address of the health insurance carrier.	
24a	Insured's policy/group no.	Enter the insurance policy number or group number.	
24b	Benefit code	Benefit code, if applicable for the billing or performing provider.	
25	Other insurance paid amount	Enter the amount paid by the other insurance company. If payment was denied, enter "Denied" in this block.	
25a	Date of notification	Enter the date of the other insurance payment or denial in this block. This must be in the format of MM/DD/CCYY.	
26	Name of referring provider	If a non-family planning service is being billed, and the service requires a referring provider, enter the provider's name.	XIX
27b	Referring NPI	If a non-family planning service is being billed and the service requires a referring provider identifier, enter the referring provider's NPI.	XIX
28	Level of practitioner	Enter the level of practitioner that performed the service. Primary care or generalist physicians and specialists are correctly classified as "Physicians." Certified nurse-midwives, nurse practitioners, clinical nurse specialists, and physician assistants providing family planning encounters are correctly categorized as "Midlevel." Family planning encounters provided by a registered nurse or a licensed vocational nurse would be categorized as "Nurse." Encounters provided by staff not included in the preceding classifications would be correctly categorized as "Other." If a client has encounters with staff members of different categories during one visit, select the highest category of staff with whom the client interacted. Optional for agencies not receiving any Title X funding.	X

Block No.	Description	Guidelines	Required
29	Diagnosis code (relate items 1, 2, 3, or 4 to item 32D by line # in 32E)	Enter the ICD-9-CM diagnosis code to the highest level of specificity available; complete to five digits for each diagnosis observed.	V, X, XIX, XX
30	Authorization number	Enter the authorization number for the client, if appropriate.	
31	Date of occurrence	Use this section when billing for complications related to sterilizations, contraceptive implants, or intrauterine devices (IUDs). This block should contain the date (MM/DD/CCYY) of the original sterilization, implant, or IUD procedure associated with the complications currently being billed.	V, X, XIX, XX, if billing complica-tions
32A	Dates of service	Enter the dates of service for each procedure provided in a MM/DD/CCYY format. If more than one DOS is for a single procedure, each date must be given (such as 3/16, 17, 18/2010). Electronic Billers Medicaid does not accept multiple (to–from) dates on a single-line detail. Bill only one date per line. **NDC** In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). Do not enter hyphens or spaces within this number. Example: N400409231231 ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.	V, X, XIX, XX
32B	Place of service	Enter the appropriate POS code for each service from the POS table under subsection 6.3.1.1, "Place of Service (POS) Coding" in this section. If the client is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service.	V, X, XIX, XX
32C	Reserved for local use	Leave this block blank. ***Note:*** *TOS codes are no longer required for claims submission.*	

Block No.	Description	Guidelines	Required
32D	Procedures, services, or supplies CPT/HCPCS modifier	Enter the appropriate CPT or HCPCS procedure codes for all procedures/services billed using the family planning services listed in Section 3, "Medicaid Title XIX family planning services" in *Gynecological and Reproductive Health, Obstetrics, and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*). **NDC** **Optional:** In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit. ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.	V, X, XIX, XX
32E	Dx. ref. (29)	Enter the diagnosis line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in Block 29. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related to must be the one identified. Do not enter more than one reference per procedure.	V, X, XIX, XX
32F	Units or days (quantity)	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). **NDC** **Optional:** In the shaded area, enter the NDC unit of measurement code. ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.	V, X, XIX, XX
	No. of participants (teen counseling)	For Teen Group Counseling, enter the total number of participants included in the teen group counseling session. Required for Title XX, Teen Group Counseling claims.	No. of partici-pants is required for Title XX teen group counselin g
32G	$ Charges	Indicate the charges for each service listed (quantity times reimbursement rate). Charges must not be higher than fees charged to private-pay clients. Approved rate tables can be found in Section 3, "Medicaid Title XIX family planning services" in *Gynecological and Reproductive Health, Obstetrics, and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).	V, X, XIX, XX

Block No.	Description	Guidelines	Required
32H (a)	Performing provider number (XIX only)—TPI	Members of a group practice (except pathology and renal dialysis groups) must identify the nine-digit TPI of the doctor/clinic within the group who performed the service. ***Note:*** *It is recommended that providers complete this block for Titles V, X, and XX when the procedure code that is entered would normally require a performing provider identifier, if it were billed under Title XIX. If a claim or encounter that was submitted for V, X, or XX is later determined as eligible to be paid from Title XIX and the performing provider identifier is missing, the claim will be denied with a request for this information. To avoid unnecessary claim or encounter denial, complete this information for all claims and encounters.*	XIX
32H (b)	Performing provider number (XIX only)—NPI	**Optional:** Members of a group practice (except pathology and renal dialysis groups) must identify NPI of the doctor/clinic within the group who performed the service. ***Note:*** *It is recommended that providers complete this block for Titles V, X, and XX when the procedure code that is entered would normally require a performing provider identifier, if it were billed under Title XIX. If a claim or encounter that was submitted for V, X, or XX is later determined as eligible to be paid from Title XIX and the performing provider identifier is missing, the claim will be denied with a request for this information. To avoid unnecessary claim or encounter denial, complete this information for all claims and encounters.*	XIX
33	Federal tax ID number/EIN (optional)	Enter the federal TIN (Employer Identification Number [EIN]) that is associated with the provider identifier enrolled with TMHP.	
34	Patient's account number (optional)	Enter the client's account number that is used in the provider's office for its payment records.	
35	Patient copay assessed	If the client was assessed a copayment (V, X, or XX), enter the dollar amount assessed. If no copay was assessed, enter $0.00. Copay cannot be assessed for Title XIX clients. Copayment must not exceed 25 percent of total charges for Title V or XX patients.	V, X, XX

Block No.	Description	Guidelines	Required
36	Total charges	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multipage claim.	V, X, XIX, XX
37	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on file" in place of the provider's signature if the billing service obtains and retains on file a letter signed and dated by the provider authorizing this practice. When providers enroll to be an electronic biller, the "Signature on file" requirement is satisfied during the enrollment process.	V, X, XIX, XX
38	Name and address of facility where services were rendered (if other than home or office)	If the services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP Code, of the facility (such as the hospital or birthing center) where the service was provided. Independently practicing health-care professionals must enter the name and number of the school district/cooperative where the child is enrolled (SHARS/ECI). For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address of the outside laboratory should be entered. The laboratory should bill Texas Medicaid for the services performed.	XIX
38a	NPI	Enter the NPI of the provider where services were rendered (if other than home or office).	XIX

Block No.	Description	Guidelines	Required
39	Physician's, supplier's billing name, address, ZIP Code, and telephone number	Enter the billing provider name, street, city, state, ZIP Code, and telephone number.	
	Teen group counseling	Providers billing Teen Group Counseling must complete the following blocks: 1. Family Planning program—should be Title XX 2. (a-b) Provider numbers/provider identifiers 3. Provider name 5. Family planning No.—Enter 999999999 (electronic billers, enter 999999999 in the Medicaid No. block) 6. Patient's name—Enter "teen group counseling" 12. Patient's Social Security number—should be 999-99-9999 29. Diagnosis code—use V2509 32A. Dates of service 32B. Place of service 32D. Procedures, services, or supplies; CPT/HCPCS modifier 32E. Dx. ref. (29) 32F. No. of participants 32G. $ Charges 33. Federal Tax ID Number/EIN 36. Total charges 37. Signature of physician or supplier	XX—teen group counseling only

6.10 Vision Claim Form

All vision services must be billed on a CMS-1500 claim form or the appropriate electronic formats. Vision claims submitted on other forms are denied with EOB 01145, "Claim form not allowed for this program."

For eyewear claims beyond program benefits, (e.g., replacing lost or destroyed eye wear), providers must have the patient sign the "Patient Certification Form" and retain in their records. Do not submit form to TMHP.

Refer to: "Vision Care Eyeglass Patient (Medicaid Client) Certification Form" in Vision and Hearing Services Handbook (Vol. 2, Provider Handbooks).

The following table shows the blocks required for vision claims on a CMS-1500 claim form.

Block No.	Description
1a	Enter the patient's nine-digit client number from the Medicaid Identification Form (H3087).
2	Enter the patient's last name, first name, and middle initial as printed on the Medicaid Identification Form (H3087).

Block No.	Description
3	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Enter the patient's complete address as described (street, city, state, and ZIP Code).
9 and 9a–9d	Other insurance or government benefits
10	Was condition related to: a. Patient's employment b. Auto accident c. Other accident
11	Medicare HIC number
12	Patient's or authorized person's signature
13*	Insured or authorized person's signature
17 Name of referring physician or other source 17b NPI	Name, provider identifiers, and address of prescribing medical doctor or doctor of optometry
21	Diagnosis or nature of illness or injury
24A	DOS
24B	POS
24D	Describe procedures, medical services, or supplies furnished for each date given
24D, Line "5" for new prescription 24D, Line "6" for old prescription	Prescription/description of lenses and frames
24E	Diagnosis pointer
24F	Charges
26*	The account number for the patient that is used in the provider's office for its billing records.
27 Check "YES" or "NO"	Accept assignment
28	Total charges
29	Amount paid by other insurance
31	Signature of physician or supplier

Block No.	Description
32	Name and address of facility where services were rendered if other than home or office
33	Telephone number
33	Physician's or supplier's name, address, city, state, and ZIP code
No longer used	Referral from screening program (THSteps)

6.11 Remittance and Status (R&S) Report

The R&S Report provides information on pending, paid, denied, and adjusted claims. TMHP provides weekly R&S Reports to give providers detailed information about the status of claims submitted to TMHP. The R&S Report also identifies accounts receivables established as a result of inappropriate payment. These receivables are recouped from claim submissions. All claims for the same provider identifier and program processed for payment are paid at the end of the week, either by a single check or with Electronic Funds Transfer (EFT). If no claim activity or outstanding account receivables exist during the cycle week, the provider does not receive an R&S Report. Providers are responsible for reconciling their records to the R&S to determine payments and denials received.

Note: *Providers receive a single R&S Report that details Texas Medicaid activities and provides individual program summaries. Combined provider payments are made based on the provider's settings for Texas Medicaid fee-for-service.*

Providers must retain copies of all R&S Reports for a minimum of five years. Providers must not use R&S Report originals for appeal purposes, but must submit copies of the R&S Reports with appeal documentation.

Refer to: Section 3, TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

6.11.1 R&S Report Delivery Options

TMHP offers three options for the delivery of the R&S Report. Although providers can choose any of the following methods, a newly-enrolled provider is initially set up to receive an PDF version of the R&S Report.

- *PDF version.* The PDF version of the R&S Report is an exact replica of the paper R&S Report. The PDF version of the R&S Report can be downloaded by registered users of the TMHP website at www.tmhp.com. The report is available each Monday morning, immediately following the weekly claims cycle. Payments associated with the R&S Report are not released until all provider payments are released on the Friday following the weekly claims cycle. *Providers who use the PDF version will not receive paper copies of the R&S Report.*
- *Paper version*. Paper R&S Reports can be mailed to providers the Friday following the weekly claims cycle. Reimbursement checks are mailed with the paper R&S Report, if the provider has not elected EFT.

  Note: *Additional copies of paper R&S Reports will be charged to the provider if requested more than 30 days after the original R&S Report was issued. There is an initial charge of $9.75 for the request (additional hours = $9.75) with a charge of $0.32 per page and applicable taxes of 8.25 percent.*

In addition to the PDF and paper versions of the R&S Report, a third, optional R&S Report delivery method is also available. Using HIPAA-compliant EDI standards, the Electronic Remittance & Status (ER&S) Report can be downloaded through the TMHP EDI Gateway using TexMedConnect or third-party software. The ER&S Report is also available each Monday after the completion of the claims processing cycle.

Refer to: Section 3, TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for more information about EDI formats and enrollment for the ER&S Report.

6.11.2 Banner Pages

Banner pages serve two purposes. First, they print the provider's name and address in a location that appears in the window of the envelope. Second, they are used to inform providers of new policies and procedures. The title pages include the following information:

- TMHP address for submitting paper appeals
- Provider's name, address, and telephone number
- Unique R&S Report number specific to each report
- Provider identifier (TPI, NPI, and atypical provider identifier [API])
- Report sequence number (indicates the week number of the year)
- Date of the week being reported on the R&S Report
- Tax Identification Number
- Page number (R&S Report begins with page 1)
- AIS telephone number
- Taxonomy code

6.11.3 R&S Report Field Explanation

- *Patient name.* Lists the client's last name and first name, as indicated on the eligibility file.
- *Claim number.* The 24-digit Medicaid ICN for a specific claim. The format for the TMHP claim number is expanded to PPP/CCC/MMM/CCYY/JJJ/BBBBB/SSS.

Acronym	Description
PPP	Program
CCC	Claim type
MMM	Media source (region)
CCYY	Year in which the claim was received
JJJ	Julian date on which the claim was received
BBBBB	TMHP internal batch number
SSS	TMHP internal claim sequence within the batch

Program Type

PPP	Program
001	Long Term Care
100	Medicaid
200	Managed Care
300	Family Planning (Titles V, X, and XX)
400	CSHCN
999	Default/summary for all media regions

Claim Type

Claim Type	Description
020	Physician/supplier (Medicaid only) (genetics agencies, THSteps [medical only], FQHC, optometrist, optician)
021	THSteps (dental)
023	Outpatient hospital, home health, RHC, FQHC
030	Physician crossovers
031	Hospital outpatient crossovers, home health crossovers, RHC crossovers
040	Inpatient hospital
050	Inpatient crossover
055	Family Planning Title V
056	Family Planning Title X
057	Family Planning Title XX
058	Family Planning Title XIX (Form 2017)

Media Source (MMM)

Region	Description
010	Paper
011	Paper adjustment
020	TDHconnect
021	TDHconnect adjustment
030	Electronic (including TexMedConnect)

Region	Description
031	Electronic adjustment (including TexMedConnect)
041	AIS adjustment
051	Mass adjustment
061	Crossover adjustment
071	Retroactive eligibility adjustment
080	State Action Request
081	State Action Request adjustment
090	Phone
091	Referral Identification Monitoring System (RIMS)
100	Fax
110	Mail
120	Encounter
121	Encounter Adjustment

- *Medicaid #.* The client's Medicaid number.
- *Patient Account #.* If a patient account number is used on the provider's claim, it appears here.
- *Medical Record #.* If a medical record number is used on the provider's claim, it appears here.
- *Medicare #.* If the claim is a result of an automatic crossover from Medicare, the last ten digits of the Medicare claim number appears directly under the TMHP claim number.
- *Diagnosis.* Primary diagnosis listed on the provider's claim.
- *Service Dates.* Format MMDDYYYY (month, day, year) in "From" and "To" dates of service.
- *TOS/Proc.* Indicates by code the specific service provided to the client. The one-digit TOS appears first followed by a HCPCS procedure code. A three-digit code represents a hospital accommodation or ancillary revenue code. For claims paid under prospective payment methodology, it is the code of the DRG.
- *Billed Quantity.* Indicates the quantity billed per claim detail.
- *Billed Charge.* Indicates the charge billed per claim detail.
- *Allowed Quantity.* Indicates the quantity TMHP has allowed per claim detail.
- *Allowed Charge.* Indicates the charges TMHP has allowed per claim detail. For inpatient hospital claims, the allowed amount for the DRG appears.
- *POS Column.* The R&S Report includes the POS to the left of the Paid Amount. A one-digit numeric code identifying the POS is indicated in this column. Refer to Subsection 6.3.1.1, "Place of Service (POS) Coding" in this section for the appropriate cross-reference among the two-digit numeric POS codes (Medicare), alpha POS codes, and one-digit numeric code on the R&S Report. Providers using electronic claims submission should continue using the same POS codes.

- *Paid Amt.* The final amount allowed for payment per claim detail. The total paid amount for the claim appears on the claim total line.
- *EOB Codes and Explanation of Pending Status (EOPS) Codes.* These codes explain the payment or denial of the provider's claim. The EOB codes are printed next to or directly below the claim. The EOPS codes appear only in "The Following Claims Are Being Processed" section of the R&S Report. The codes explain the status of pending claims and are not an actual denial or final disposition. An explanation of all EOB and EOPS codes appearing on the R&S Report are printed in the Appendix at the end of the R&S Report. Up to five EOB codes are displayed.
- *Benefit.* Indicates the three digit benefit code associated with the claim.
- *Modifier.* Modifiers have been developed to describe and qualify services provided. For THSteps dental services two modifiers are printed. The first modifier is the TID and the second is the SID.

Refer to: Subsection 6.2.7, "Modifier Requirements for TOS Assignment" in this section for a list of the most commonly used modifiers.

6.11.4 R&S Report Section Explanation

6.11.4.1 Claims – Paid or Denied

The heading *Claims – Paid or Denied Claims* is centered on the top of each page in this section. Claims in this section finalized the week before the preparation of the R&S Report. The claims are sorted by claim status, claim type, and by order of client names. The reported status of each claim will not change unless further action is initiated by the provider, HHSC, or TMHP.

The following information is provided on a separate line for all inpatient hospital claims processed according to prospective payment methodology:

- *Age.* Client's age according to TMHP records
- *Sex.* Client's sex according to TMHP records:
  M = Male, F = Female, U = Unknown
- *Pat-Stat.* Indicates the client's status at the time of discharge or the last DOS on the claim (refer to instructions for UB-04 CMS-1450 claim form, Block 17)
- *Proc.* ICD-9-CM code indicates the primary surgical procedure used in determining the DRG

Important: *Only paper claims appear in this section of the R&S Report. Claims filed electronically without required information are rejected. Users are required to retrieve the response file to determine reasons for rejections.*

TMHP cannot process incomplete claims. Incomplete claims may be submitted as original claims only if the resubmission is received by TMHP within the original filing deadline.

Refer to: Subsection 6.1, "Claims Information" in this section for a description of different claim types.

6.11.4.2 Adjustments to Claims

Adjustments – Paid or Denied is centered at the top of each page in this section. Adjustments are sorted by claim type and then patient name and Medicaid number. Media types 011, 021, 031, 041, 051, 061, 071, and 081 appear in this section. An adjustment prints in the same format as a paid or denied claim.

The adjusted claim is listed first on the R&S Report. EOB 00123, "This is an adjustment to previous claim XXXXXXXXXXXXXXXXXXXXXXXXX which appears on R&S Report dated XX/XX/XX" follows this claim. Immediately below is the claim as originally processed. An accounts receivable is created for the original claim total as noted by EOB 00601, "A receivable has been established in the amount of the original payment: $XXX,XXX,XXX.XX. Future payments will be reduced or withheld until such amount

is paid in full." prints below the claim indicating the amount to be recouped. This amount appears under the heading, "Financial Transactions Accounts Receivable." EOB 06065, "Account Receivable is due to the adjusted claim listed. For details, refer to your R&S Report for the date listed within the original date field."

Claims adjusted as a result of a rate change will be listed on the R&S Report with EOB 01154 "This adjustment is a result of a rate change."

Refer to: Subsection 6.2.7, "Modifier Requirements for TOS Assignment" in this section for a list of the most commonly used modifiers.

6.11.4.3 Financial Transactions

All claim refunds, reissues, voids/stops, recoupments, backup withholdings, levies, and payouts appear in this section of the R&S Report. The Financial Transactions section does not use the R&S Report form headings. Additional subheadings are printed to identify the financial transactions. The following descriptions are types of financial items:

6.11.4.3.1 Accounts Receivable

This label identifies money subtracted from the provider's current payment owed to TMHP. Specific claim data are not given on the R&S Report unless the accounts receivable control number is provided which should be referenced when corresponding with TMHP. Accounts receivable appear on the R&S Report in the following format:

- *Control Number.* A number to reference when corresponding with TMHP.
- *Recoupment Rate.* The percentage of the provider's payment that is withheld each week unless the provider elects to have a specific amount withheld each week.
- *Maximum Periodic Recoupment Amount.* The amount to be withheld each week. This area is blank if the provider elects to have a percentage withheld each week.
- *Original Date.* The date the financial transaction was processed originally.
- *Original Amount.* The total amount owed TMHP.
- *Prior Date.* The date the last transaction on the accounts receivable occurred.
- *Prior Balance.* The amount owed from a previous R&S Report.
- *Applied Amount.* The amount subtracted from the current R&S Report.
- *FYE.* The fiscal year end (FYE) for cost reports.
- *EOB.* The EOB code that corresponds to the reason code for the accounts receivable.
- *Patient Name.* The name of the patient on the claim, if the accounts receivable are claim-specific.
- *Claim Number.* The ICN of the original claim, if the accounts receivable are claim-specific.
- *Backup Withholding Penalty Information.* A penalty assessed by the Internal Revenue Service (IRS) for noncompliance due to a B-Notice. Although the current payment amount is lowered by the amount of the backup withholding, the provider's 1099 earnings are not lowered.
- *Control Number.* TMHP control number to reference when corresponding with TMHP.
- *Original Date.* The date the backup withholding was set up originally.
- *Withheld Amount.* Amount withheld (31 percent) of the provider's checkwrite.

6.11.4.3.2 IRS Levies

The payments withheld from a provider's checkwrite as a result of a notice from the IRS of a levy against the provider appear in the "IRS Levy Information" section of the R&S Report. Payments are withheld until the levy is satisfied or released. Although the current payment amount is lowered by the amount of the levy payment, the provider's 1099 earnings are not lowered. IRS levies are reported in the following format:

- *Control Number.* TMHP control number to reference when corresponding with TMHP.
- *Maximum Recoupment Rate.* The percentage of the provider's payment that is withheld each week, unless the provider elects to have a specific amount withheld each week.
- *Maximum Recoupment Amount.* The amount to be withheld periodically.
- *Original Date.* The date the levy was set up originally.
- *Original Amount.* The total amount owed to the IRS.
- *Prior Balance.* The amount owed from a previous R&S Report.
- *Prior Date.* The date the last transaction on the levy occurred.
- *Current Amount.* The amount subtracted from the current R&S Report and paid to the IRS.
- *Remaining Balance.* The amount still owed on the levy. (This amount becomes the "previous balance" on the next R&S Report.)

6.11.4.3.3 Refunds

Refunds are identified by EOB 00124, "Thank you for your refund; your 1099 liability has been credited." This statement is verification that dollars refunded to TMHP for incorrect payments have been received and posted. The provider's check number and the date of the check are printed on the R&S Report. Claim refunds appear on the R&S Report in the following format:

- Claim Specific:
  - *ICN.* The claim number of the claim to which the refund was applied this cycle.
  - *Patient Name.* The first name, middle initial, and last name of the patient on the applicable claim.
  - *Medicaid Number.* The patient's Medicaid or CSHCN number.
  - *Date of Service.* The format MMDDCCYY (month, day, and year) in "From" DOS.
  - *Total Billed.* The total amount billed for the claim being refunded.
  - *Amount Applied This Cycle.* The refund amount applied to the claim.
  - *EOB.* Corresponds to the reason code assigned.
- Nonclaim Specific:
  - *Control Number.* A control number to reference when corresponding with TMHP.
  - *FYE.* The fiscal year for which this refund is applicable.
  - *EOB.* Corresponds to the reason code assigned.

6.11.4.3.4 Payouts

Payouts are dollars TMHP owes to the provider. TMHP processes two types of payouts: system payouts that increase the weekly check amount and manual payouts that result in a separate check being sent to the provider. Specific claim data are not given on the R&S Report for payouts. A control number is given, which should be referenced when corresponding with TMHP. System and manual payouts appear on the R&S Report in the following format:

- *Payout Control Number.* A control number to reference when corresponding with TMHP.
- *Payout Amount.* The amount of the payout.
- *FYE.* The fiscal year for which the payout is applicable.
- *EOB.* Corresponds to the reason code assigned.
- *Patient Name.* Name of the patient (if available).
- *PCN.* Medicaid number of the patient (if available).
- *DOS.* Date of service (if available).

6.11.4.3.5 Reissues

The provider's 1099 earnings are not affected by reissues. A messages states, "Your payment has been increased by the amount indicated below:

- *Check Number.* The number of the original check.
- *Check Amount.* The amount of the original check.
- *R&S Number.* The number of the original R&S Report.
- *R&S Date.* The date of the original R&S Report.

6.11.4.3.6 Voids and Stops

The provider's 1099 earnings are credited by the amount of the voided/stopped payment.

- *Check Number.* The number of the voided/stopped payment.
- *Check Amount.* The amount of the voided/stopped payment.
- *R&S Number.* The number of the voided/stopped payment.
- *R&S Date.* The date of the voided/stopped payment.

6.11.4.4 Claims Payment Summary

This section summarizes all payments, adjustments, and financial transactions listed on the R&S Report. The section has two categories: one for amounts "Affecting Payment This Cycle" and one for "Amount Affecting 1099 Earnings."

If the provider is receiving a check on this particular R&S Report, the following information is given: "Payment summary for check XXXXXXXXX in the amount of XXX,XXX,XXX.XX." If the payment is EFT: "Payment summary for direct deposit by EFT XXXXXXXXX in the amount of XXX,XXX,XXX.XX." The check number also is printed on the check that accompanies the R&S Report.

Headings for the Payment Summary for "Affecting Payment This Cycle" and "Amount Affecting 1099 Earnings"

- *Claims Paid.* Indicates the number of claims processed for the week and the year-to-date total.
- *System Payouts.* The total amount of system payouts made to the provider by TMHP.
- *Manual Payouts (Remitted by separate check or EFT).* The total amount of manual payouts made to the provider by TMHP.
- *Amount Paid to IRS for Levies.* The amount remitted to IRS and withheld from the provider's payment due to an IRS levy.
- *Amount Paid to IRS for Backup Withholding.* The amount paid to the IRS for backup withholding.
- *Accounts Receivable Recoupments.* The total amount withheld from the provider's payment due to accounts receivable.

- *Amounts Stopped/Voided.* The total amount of the payment that was voided or stopped with no reissuance of payment.
- *System Reissues.* The amount of the reissed payment.
- *Claim Related Refunds.* The total amount of claim-related refunds applied during the weekly cycle.
- *Nonclaim Related Refunds.* The total amount of nonclaim-related refunds applied during the weekly cycle.
- *Approved to Pay/Deny Amount.* The total amount of claim payments that were approved to pay/deny within the week. (This column will not be used at this time.)
- *Pending Claims.* The total amount billed for claims in process as of the cutoff date for the report.

6.11.4.5 The Following Claims are Being Processed

In the "Following Claims are Being Processed" section, the R&S Report may list up to five EOPS codes per claim. The claims listed in this section are in process and *cannot be appealed for any reason* until they appear in either the "Claims Paid or Denied," or "Adjustments Paid and Denied" sections of the R&S Report. TMHP is listing the pending status of these claims for informational purposes only. *The pending messages should not be interpreted as a final claim disposition.* Weekly, all claims and appeals on claims TMHP has "in process" from the provider are listed on the R&S Report. The Following Claims are Being Processed claim prints in the same format as a paid or denied claim.

6.11.4.6 Explanation of Benefit Codes Messages

This section lists the descriptions of all EOBs that appeared on the R&S Report. EOBs appear in numerical order.

6.11.4.7 Explanation of Pending Status Codes Appendix

This section lists the description of all EOPS codes that appeared on the R&S Report. EOPS appear in numerical order.

EOB and EOPS codes may appear on the same pending claim because some details may have already finalized while others may have questions and are pending.

6.11.5 R&S Report Examples

See the following pages for examples of R&S Reports.

6.11.6 Banner Page R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2010

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0855

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
R&S Number: 2460000

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BANNER PAGE

(10/24/08 THROUGH 11/14/08) *****ATTENTION ALL MEDICAID PROVIDERS*****

Effective for dates of service on or after September 1, 2007, the Texas Medicaid Program is implementing benefit changes for respiratory syncytial virus (RSV) prophylaxis palivizumab (Synagis). Details of these changes are available on the TMHP website at www.tmhp.com and will also be available in the January/February 2008 *Texas Medicaid Bulletin*, No. 212. For more information, call the TMHP Contact Center at 1-800-925-9126

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

YOUR AIS NUMBER IS 0000000-01
FOR AIS INQUIRY CALL TOLL FREE 1-(800) 925-9126
THE PROVIDER MANUAL PROVIDES DETAILS.
PHYSICAL ADDRESS ON RECORD:
TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234

(214) 555-4141

6.11.6.1 Paid or Denied Claims (Hospital) R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2010

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0855

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
R&S Number: 2460000

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PATIENT NAME	CLAIM NUMBER	MEDICAID #	PATIENT ACCT #	MEDICAL RECORD # / PATIENT ACCT #	MEDICARE #	EOB	EOB	EOB	EOB	DIAGNOSIS
		---SERVICE DATES---		-----BILLED-----	-----ALLOWED-----					
FROM TO	TOS PROC	QTY	CHARGE	QTY CHARGE POS	PAID AMT	EOB	EOB	EOB	EOB EOB	MOD MOD
********** CLAIMS - PAID OR DENIED **********										
DOE, JANE	10004001020071234567 8912		123456789	1300	01147					V700
05/22/2008 05/22/2008	1 T1015	1.0	71.00	.0 .00 5	.00	00013				U7
			$71.00	$.00	$.00	CLAIM TOTAL				
00139 PAYMENT WAS REDUCED BY 37.95 DUE TO OTHER INSURANCE PAYMENTS										
DOE, JANE	10004003020071236547 8963		123456789	N12505-010017	01147					V6519
08/20/2008 08/20/2008	1 T1015	1.0	71.00	.0 .00 5	.00	00013				AM
			$71.00	$.00	$.00	CLAIM TOTAL				

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.

6.11.6.2 Paid or Denied Claims (Physician) R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2010

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0855

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
R&S Number: 2460000

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PATIENT NAME / PATIENT ACCT #	CLAIM NUMBER	MEDICAID #	PATIENT ACCT #	MEDICAL RECORD #	MEDICARE #	EOB	EOB	EOB	EOB	DIAGNOSIS
---SERVICE DATES---		-----BILLED-----	-----ALLOWED-----							
FROM TO	TOS PROC	QTY CHARGE	QTY CHARGE	POS	PAID AMT	EOB	EOB	EOB	EOB EOB	MOD MOD
********** CLAIMS - PAID OR DENIED **********										
DOE, JANE 0000	10003001020070440000000	123456789			01147					53081
01/04/2009 01/04/2009	3 99252	1.0 226.00	1.0 56.46	3	55.05	00000	00475	01004		
		$226.00	$56.46		$55.05	CLAIM TOTAL				
PAID CLAIM TOTALS		$226.00	$56.46		$55.05					

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.

6.11.6.3 Adjustments R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2010

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0855

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
R&S Number: 2460000

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PATIENT NAME / PATIENT ACCT #	CLAIM NUMBER	MEDICAID #	PATIENT ACCT #	MEDICAL RECORD #	MEDICARE #	EOB	EOB	EOB	EOB	DIAGNOSIS
---SERVICE DATES---		-----BILLED-----	-----ALLOWED-----							
FROM TO	TOS PROC	QTY CHARGE	QTY CHARGE	POS	PAID AMT	EOB	EOB	EOB	EOB	EOB	MOD MOD

********** ADJUSTMENTS - PAID OR DENIED **********

ADJUSTMENT CLAIM:
DOE, JANE 10002101120073466666666 123456789 00207
11111
02/17/2008 02/17/2008 W D7280 1.0 600.00 .0 .00 1 .00 01147 J

$600.00 $.00 $.00 ADJUSTMENT CLAIM TOTAL

00123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 10002102020073555555555 WHICH APPEARS ON R&S DATED 01/14/2007

ORIGINAL CLAIM:
DOE, JANE 10002102020073555555555 123456789 01147
11111
02/17/2008 02/17/2008 W D7280 1.0 600.00 1.0 62.50 1 60.94 00149 01004 J

$600.00 $62.50 $60.94 ORIGINAL CLAIM TOTAL

00601 A RECEIVABLE HAS BEEN ESTABLISHED IN THE AMOUNT OF THE ORIGINAL PAYMENT: $60.94. FUTURE PAYMENTS WILL BE REDUCED OR WITHHELD UNTIL SUCH AMOUNT IS PAID IN FULL.

****

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.

6.11.6.4 Claims in Process R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2010

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0855

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
R&S Number: 2460000

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PATIENT NAME CLAIM NUMBER MEDICAID # PATIENT ACCT # MEDICAL RECORD # MEDICARE # EOPS EOPS EOPS EOPS DIAGNOSIS
PATIENT ACCT #
---SERVICE DATES--- -----BILLED----- -----ALLOWED-----
FROM TO TOS PROC QTY CHARGE QTY CHARGE POS PAID AMT EOPS EOPS EOPS EOPS EOPS MOD MOD

********** THE FOLLOWING CLAIMS ARE BEING PROCESSED **********

THE EXPLANATION OF PENDING STATUS (EOPS) CODES LISTED ARE NOT FINAL CLAIM DENIALS OR PAYMENT DISPOSITIONS. THE EOPS CODES IDENTIFY THE REASONS WHY A CLAIM IS IN PROCESS. BECAUSE THESE CLAIMS ARE CURRENTLY IN PROCESS, NEW INFORMATION CANNOT BE ACCEPTED TO MODIFY THE CLAIM UNTIL THE CLAIM FINALIZES AND APPEARS AS FINALIZED ON YOUR R&S REPORT. PLEASE REFER TO THE LAST SECTION OF THIS REPORT FOR THE MESSAGES THAT CORRESPOND TO THE EOPS CODES USED ON THIS REPORT.

DOE, JANE 10002003020071234567891O 123456789 00A01 78605
01/15/2008 01/15/2008 1 99213 1.0 201.03

$201.03

PENDING CLAIM TOTALS $201.03

****

IF YOUR CLAIM HAS NOT APPEARED ON AN R&S REPORT AS PAID, DENIED OR PENDING WITHIN 30 DAYS OF SUBMISSION TO TMHP, PLEASE CONTACT TELEPHONE INQUIRY AT 1-800-925-9126 AND/OR SEE CLAIMS FILING INSTRUCTIONS IN YOUR PROVIDER MANUAL.

6.11.6.5 System Payouts R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2010

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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PAYOUT CONTROL NUMBER	PAYOUT AMOUNT	FYE	EOB	REFUND CHECK NUMBER	REFUND CHECK AMOUNT	PATIENT NAME	PCN	DOS
********** FINANCIAL TRANSACTIONS **********								
SYSTEM PAYOUTS								
YOUR PAYMENT FOR MEDICAID HAS BEEN INCREASED FOR THE REASON INDICATED BELOW.								
2008999999999	6.19		06135	22152	222.00			
2008999999999	1,442.00		06135					
TOTAL FOR MEDICAID:	$ 1,448.19							
YOUR PAYMENT FOR MANAGED CARE HAS BEEN INCREASED FOR THE REASON INDICATED BELOW.								
2008999999999	989.00		00330					
TOTAL FOR MANAGED CARE:	$ 989.00							

****

6.11.6.6 Manual Payouts R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2010

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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PAYOUT CONTROL NUMBER	PAYOUT AMOUNT	FYE	EOB	REFUND CHECK NUMBER	REFUND CHECK AMOUNT	PATIENT NAME	PCN	DOS

********** FINANCIAL TRANSACTIONS **********

MANUAL PAYOUTS

A CHECK FOR MEDICAID HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW.

2008999999999	1,442.00	2008	06005

TOTAL FOR MEDICAID: $ 1,442.00

A CHECK FOR MANAGED CARE HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW.

2008999999999	7,800.00	2006	06012

TOTAL FOR MANAGED CARE: $ 7,800.00

****

6.11.6.7 Accounts Receivables R&S Report

For purposes of example, accounts receivables, void, and stop pay appear together on the following R&S Report example.

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2010

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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CONTROL NUMBER	RECOUPMENT RATE / MAXIMUM PERIODIC RECOUPMENT AMOUNT	ORIGINAL DATE / ORIGINAL AMOUNT	PRIOR DATE / PRIOR BALANCE	APPLIED AMOUNT	PROGRAM	FYE	EOB	PATIENT NAME / CLAIM NUMBER
********** FINANCIAL TRANSACTIONS **********								
ACCOUNTS RECEIVABLE								
YOUR PAYMENT WAS REDUCED BY THE APPLIED AMOUNTS SHOWN BELOW FOR THE REASONS INDICATED.								
2008299999999	50% / 67,281.00	08/01/2008 / 67,281.00	08/02/2008 / 65,417.90	926.34	MGD CARE		06022	
$1,597.00 WAS RECOVERED ON THIS ACCOUNT RECEIVABLE FROM AN AFFILIATED PROVIDER.								
2008299999999	50% / 67,281.00	08/01/2008 / 67,281.00	08/02/2008 / 64,491.56	550.29	MEDICAID		06022	
$1,597.00 WAS RECOVERED ON THIS ACCOUNT RECEIVABLE FROM AN AFFILIATED PROVIDER.								
2008299999999	25% / 2,700.00	08/15/2008 / 2,700.00	00/00/0000 / 2,700.00	137.57	MEDICAID		06022	
2008299999999	25% / 2,700.00	08/15/2008 / 2,700.00	00/00/0000 / 2,562.43	231.58	MGD CARE		06022	
2008299999999	100% / 96.98	08/15/2008 / 96.98	08/02/2008 / 96.98	96.98	MEDICAID	2008	06065	DOE, JANE / 10003103020089999999999
2008299999999	100% / 1,080.44	08/15/2008 / 1,080.44	08/02/2008 / 1,080.44	1,080.44	MGD CARE	2008	06065	DOE, JANE / 20003103020089999999999
2008299999999	100% / 126.68	08/15/2008 / 126.68	08/04/2008 / 126.68	126.68	MGD CARE	2007	06065	DOE, JANE / 20003103020079999999999
TOTAL RECOUPED:				$ 3,149.88				

6.11.6.8 Void and Stop Pay R&S Report

```
                                Texas Medicaid & Healthcare Partnership
                                      Remittance and Status Report
                                           Date: 02/01/2010
Mail original claim to:                                          Texas Provider
Texas Medicaid & Healthcare Partnership                          P.O. BOX 848484
P.O. Box 200555                                                  Dallas, TX 75888-1234
Austin, Texas 78720-0555                                         (214) 555-4141

Mail all other correspondence to:                                TPI:  1234567-01
Texas Medicaid & Healthcare Partnership                          NPI/API:  1234567890
12357-B Riata Trace Parkway                                      Taxonomy:  193400000X
Austin, Texas 78727-6422                                         Benefit Code:
                                                                 Report Seq. Number:  33
(800) 925-9126                                                   R&S Number:    99999999

~                                                                                                                    Page 29 Of
_____________________________________________________________________________________________________________________________

********************************************************** FINANCIAL TRANSACTIONS ***************************************************************

VOIDS AND STOPS FOR MEDICAID

CHECK NUMBER:  000000000               AMOUNT:          116.20          R&S NUMBER:   123456789        R&S DATE:  09/28/2007


TOTAL FOR MEDICAID:                                 $ 116.20

VOIDS AND STOPS FOR MANAGED CARE

CHECK NUMBER:  000000000               AMOUNT:          194.79          R&S NUMBER:   123456789        R&S DATE:  09/28/2007


TOTAL FOR MANAGED CARE:                             $ 194.79

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```

6.11.6.9 Refunds for Medicaid R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2010

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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********** FINANCIAL TRANSACTIONS **********

REFUNDS FOR MEDICAID

YOUR REFUND CHECK #999999999 DATED 07/03/2008 WAS RECEIVED BY TMHP AND APPLIED AS FOLLOWS:

CLAIM-SPECIFIC:

ICN	PATIENT NAME	CLIENT NUMBER	DATE OF SERVICE	TOTAL BILLED	AMOUNT APPLIED THIS CYCLE	EOB
10002302120079999999999	LAST, FIRST NAME	123456789	05/31/2007	25.00	6.19	00124
					13.60	00124
Subtotal Claim Specific					$ 19.79	

NON-CLAIM-SPECIFIC:

PAYOUT CASH CONTROL NUMBER	FYE	EOB	AMOUNT APPLIED THIS CYCLE
2008999999999	0000	06067	6.19
Subtotal Non-Claim Specific			$ 6.19

TOTAL FOR MEDICAID: $ 25.98

REFUNDS FOR MANAGED CARE

6.11.6.10 Refunds for Managed Care R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2010

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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********** FINANCIAL TRANSACTIONS **********

REFUNDS FOR MANAGED CARE

YOUR REFUND CHECK #000022152 DATED 07/03/2008 WAS RECEIVED BY TMHP AND APPLIED AS FOLLOWS:

CLAIM-SPECIFIC:

ICN	PATIENT NAME	CLIENT NUMBER	DATE OF SERVICE	TOTAL BILLED	AMOUNT APPLIED THIS CYCLE	EOB
20002302020079999999999	LAST, FIRST NAME	999999999	05/01/2007	124.33	27.02	00124
					11.00	00124
Subtotal Claim Specific					$ 38.02	

TOTAL FOR MANAGED CARE: $ 38.02

6.11.6.11 IRS Levy R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2010

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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CONTROL NUMBER	-- MAXIMUM RECOUPMENT -- RATE	AMOUNT	ORIGINAL DATE	ORIGINAL AMOUNT	PRIOR BALANCE	PRIOR DATE	CURRENT AMOUNT	REMAINING BALANCE
********** FINANCIAL TRANSACTIONS **********								
IRS LEVY INFORMATION FOR MEDICAID:								
2008299999999	20%	554.00	08/02/2008	554.00	554.00	08/02/2008	.00	554.00
IRS LEVY INFORMATION FOR MANAGED CARE:								
2008999999999	20%	554.00	08/02/2008	554.00	554.00	08/02/2008	554.00	.00

PAYMENT(S) TOTALING $554.00 WERE REMITTED ON YOUR BEHALF TO THE INTERNAL REVENUE SERVICE DUE TO THE LEVY THAT IS DESCRIBED ABOVE.

****

6.11.6.12 Backup Withholding Penalty Information R&S Report

```
                                  Texas Medicaid & Healthcare Partnership
                                       Remittance and Status Report
                                            Date: 02/01/2010
Mail original claim to:                                          Texas Provider
Texas Medicaid & Healthcare Partnership                          P.O. BOX 848484
P.O. Box 200555                                                  Dallas, TX 75888-1234
Austin, Texas 78720-0555                                         (214) 555-4141

Mail all other correspondence to:                                TPI:  1234567-01
Texas Medicaid & Healthcare Partnership                          NPI/API:  1234567890
12357-B Riata Trace Parkway                                      Taxonomy:  193400000X
Austin, Texas 78727-6422                                         Benefit Code:
                                                                 Report Seq. Number:  33
(800) 925-9126                                                   R&S Number:    99999999

~                                                                                                                  Page 23 Of
_____________________________________________________________________________________________________________________________

 PROGRAM        CONTROL NUMBER    ORIGINAL DATE      WITHHELD AMOUNT
_____________________________________________________________________________________________________________________________

********************************************************** FINANCIAL TRANSACTIONS ***************************************************************

BACKUP WITHHOLDING PENALTY INFORMATION:

 OUR RECORDS INDICATE THAT YOU HAVE BEEN ASSESSED A PENALTY BY THE INTERNAL REVENUE SERVICE FOR NON-COMPLIANCE WITH BACKUP WITHHOLDING
 REQUIREMENTS.  THEREFORE, YOUR PAYMENT HAS BEEN LOWERED AND THE PENALTY AMOUNT HAS BEEN REMITTED TO THE INTERNAL REVENUE SERVICE.
 28% OF YOUR PAYMENT AMOUNT WILL BE WITHHELD WEEKLY UNTIL TMHP RECEIVES A W9 OR LETTER 147C AS REQUESTED IN A B-NOTICE PREVIOUSLY SENT TO
 YOUR FACILITY OR OFFICE.

 MEDICAID:      2008999999999     08/02/2008                 428.00


 MANAGED CARE:  2008999999999     08/02/2008                 935.93

*****************************************************************************************************************************************
```

6.11.6.13 Reissues R&S Report

```
                                  Texas Medicaid & Healthcare Partnership
                                       Remittance and Status Report
                                            Date: 02/01/2010
Mail original claim to:                                          Texas Provider
Texas Medicaid & Healthcare Partnership                          P.O. BOX 848484
P.O. Box 200555                                                  Dallas, TX 75888-1234
Austin, Texas 78720-0555                                         (214) 555-4141

Mail all other correspondence to:                                TPI:  1234567-01
Texas Medicaid & Healthcare Partnership                          NPI/API:  1234567890
12357-B Riata Trace Parkway                                      Taxonomy:  193400000X
Austin, Texas 78727-6422                                         Benefit Code:
                                                                 Report Seq. Number:  33
(800) 925-9126                                                   R&S Number:    99999999

~                                                                                                                    Page 31 Of
_____________________________________________________________________________________________________________________________________

********************************************************** FINANCIAL TRANSACTIONS ***************************************************************

REISSUES

  YOUR PAYMENT FOR MEDICAID HAS BEEN INCREASED BY THE AMOUNT INDICATED BELOW:

 CHECK NUMBER: 099999999               AMOUNT:        8,300.88         R&S NUMBER:    99999999          R&S DATE:  08/17/2007

 CHECK NUMBER: 099999999               AMOUNT:        3,411.72         R&S NUMBER:    11111111          R&S DATE:  03/07/2008

TOTAL FOR MEDICAID:                                $ 11,712.60

  YOUR PAYMENT FOR MANAGED CARE HAS BEEN INCREASED BY THE AMOUNT INDICATED BELOW:

 CHECK NUMBER: 099999999               AMOUNT:        8,330.88         R&S NUMBER:    99999999          R&S DATE:  08/17/2007

 CHECK NUMBER: 099999999               AMOUNT:          307.43         R&S NUMBER:    11111111          R&S DATE:  03/07/2008

TOTAL FOR MANAGED CARE:                             $ 8,638.31

*****************************************************************************************************************************************
```

6.11.6.14 Sub-Owner Recoupments R&S Report

```
                                  Texas Medicaid & Healthcare Partnership
                                       Remittance and Status Report
                                            Date: 02/01/2010
Mail original claim to:                                        Texas Provider
Texas Medicaid & Healthcare Partnership                        P.O. BOX 848484
P.O. Box 200555                                                Dallas, TX 75888-1234
Austin, Texas 78720-0555                                       (214) 555-4141

Mail all other correspondence to:                              TPI:  1234567-01
Texas Medicaid & Healthcare Partnership                        NPI/API:  1234567890
12357-B Riata Trace Parkway                                    Taxonomy:  193400000X
Austin, Texas 78727-6422                                       Benefit Code:
                                                               Report Seq. Number:  33
(800) 925-9126                                                 R&S Number:    99999999

~                                                                                                                Page 32 Of
_____________________________________________________________________________________________________________________________
                                        CONTROL NUMBER                    RECOUPMENT AMOUNT     PROGRAM
_____________________________________________________________________________________________________________________________
********************************************************** FINANCIAL TRANSACTIONS ***************************************************************

SUB-OWNER RECOUPMENTS

RECOUPMENT IS A RESULT OF YOUR AFFILIATION WITH ANOTHER PROVIDER.

                                        2007999999999                       10.53     MEDICAID

                                        2007999999999                        9.47     MGD CARE

TOTAL RECOUPED:                                                          $ 20.00

*****************************************************************************************************************************************************
```

6.11.6.15 Summary R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2010

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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PAYMENT SUMMARY FOR TAX ID 123456789

	*** AFFECTING PAYMENT THIS CYCLE *** AMOUNT	COUNT	*** AMOUNT AFFECTING 1099 EARNINGS *** THIS CYCLE	YEAR TO DATE
CLAIMS PAID	3,738.10	9	3,738.10	35,676.72
SYSTEM PAYOUTS	2,437.19		2,437.19	2,437.19
MANUAL PAYOUTS (REMITTED BY SEPARATE CHECK OR EFT)			9,242.00	9,242.00
AMOUNT PAID TO IRS FOR LEVIES	-554.00			
AMOUNT PAID TO IRS FOR BACKUP WITHHOLDING	-1,363.93			
ACCOUNTS RECEIVABLE RECOUPMENTS	-3,149.88		-3,149.88	-9,314.02
AMOUNTS STOPPED/VOIDED			-310.99	-310.99
SYSTEM REISSUES	20,350.91			
CLAIM RELATED REFUNDS			-57.81	-57.81
NON-CLAIM RELATED REFUNDS			-6.19	-6.19
HELD AMOUNT	-4,291.67			
PAYMENT AMOUNT	17,166.72		11,892.42	37,666.90

PENDING CLAIMS 54,913.83

THE AMOUNT OF $4,291.67 WAS HELD AT THE DIRECTION OF THE STATE MEDICAID AGENCY.

**********PAYMENT TOTAL FOR DIRECT DEPOSIT BY EFT 000000099999999 IN THE AMOUNT OF 17,166.72.**********

6.11.6.16 Appendix R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2010

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0855

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
R&S Number: 2460000

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EXPLANATION OF BENEFITS CODES MESSAGES

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOB CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

00100	A CHARGE WAS NOT NOTED FOR THIS SERVICE.
00149	PROCEDURE PAYMENT BASED ON PROGRAM/BENEFIT PLAN, DATE OF SERVICE AND A MAXIMUM PAYMENT AMOUNT SET BY CMS OR HHSC.
00429	THIS SURGERY/SERVICE/SITUATION DESCRIBED IS NOT ON THE AUTHORIZATION LETTER AND IS NOT PAYABLE.
00475	PAID ACCORDING TO THE TEXAS MEDICAID REIMBURSEMENT METHODOLOGY-TMRM (RELATIVE VALUE UNIT TIMES STATEWIDE CONVERSION FACTOR)
00572	IT IS MANDATORY THAT AUTHORIZATION BE OBTAINED. DUE TO THE LACK OF APPROVAL, THE SERVICE IS NON-PAYABLE.
00757	PROCEDURE PAYMENT BASED ON PROGRAM/BENEFIT PLAN, DATE OF SERVICE AND IS CALCULATED AT THE DETAIL BILLED AMOUNT.
01004	THIS PAYMENT WAS REDUCED 2.5% IN ACCORDANCE WITH THE 78TH TEXAS LEGISLATURE, ARTICLE II OF HOUSE BILL 1, AND SECTION 2.03 OF HOUSE BILL 2292.
01147	PLEASE REFER TO OTHER EOB MESSAGES ASSIGNED TO THIS CLAIM FOR PAYMENT/DENIAL INFORMATION.

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOP CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

00I03	OUR FILES INDICATE AN AUTHORIZATION INFORMATION MISMATCH.

6.11.7 Provider Inquiries—Status of Claims

TMHP provides several effective mechanisms for researching the status of a claim. Weekly, TMHP provides the R&S Report reflecting all claims with a paid, denied, or pending status. Providers verify claim status using the provider's log of pending claims.

Electronic billers allow ten business days for a claim to appear on their R&S Reports. If the claim does not appear on an R&S Report as paid, pending, or denied, a transmission failure, file rejection, or claims rejection may exist. Providers check records for transmission reports correspondence from the TMHP EDI Help Desk.

The provider allows at least 30 days for a Medicaid paper claim to appear on an R&S Report after the claim has been submitted to TMHP. If a claim has not been received by TMHP and must be submitted a second time, the second claim must also meet the 95-day filing deadline.

The provider allows TMHP 45 days to receive a Medicare-paid claim automatically transmitted for payment of deductible, coinsurance, or both. Claims that fail to cross over from Medicare may be filed to TMHP by submitting a paper MRAN received from Medicare or a Medicare intermediary, the computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services or the TMHP Standardized MRAN form with the completed claim form.

If the claim does not appear on an R&S Report as paid, pending, or denied, providers can use any of the following procedures to inquire about the status of the claim:

- The provider can use the claim status inquiry function of TexMedConnect on the TMHP website at www.tmhp.com.
- The provider can call AIS at 1-800-925-9126 to determine if the claim is pending, paid, denied, or if TMHP has no record of the claim.
- If any of the three options above indicates that TMHP has no record of the claim, the provider can call the TMHP Contact Center at 1-800-925-9126 and speak to a TMHP contact center representative.
- If the TMHP Contact Center has no record of a claim that was submitted within the original filing deadline, the provider can submit a copy of the original claim to TMHP for processing. Electronic billers may refile the claim electronically. For claims submitted by a hospital for inpatient services, the filing deadline is 95 days from the discharge date or the last DOS on the claim. For all other types of providers, the filing deadline is 95 days from each DOS on the claim.
- If the 95-day filing deadline has passed and the claim is still within 120 days of the date of the rejection report or the R&S Report, the provider can submit a signed copy of the claim and all of the documentation that supports the original claim submission, including any electronic rejection reports, to:

  Texas Medicaid & Healthcare Partnership
  Inquiry Control Unit
  12357-A Riata Trace Parkway, Suite 100
  Austin, TX 78727

Providers must retain copies of all R&S Reports for a minimum of five years. Providers must not send original R&S Reports back with appeals. Providers must submit one copy of the R&S Report to TMHP per appeal.

Refer to: "Automated Inquiry System (AIS)" in TMHP Telephone and Address Guide (*Vol. 1, General Information*).

6.12 Other Insurance Claims Filing

The following information must be provided in the "Other Insurance" field on the paper claim and in the appropriate field of electronic claims. On the CMS-1500 paper claim form, Fields 9 or 11, and 29 must contain the appropriate information:

- Name of the other insurance resource
- Address of the other insurance resource
- Policy number and group number
- Policyholder
- Effective date if available
- Date of disposition by other insurance resource (used to calculate filing deadline)
- Payment or specific denial information

Important: *Important: By accepting assignment on a claim for which the client has Medicaid coverage, providers agree to accept payment made by insurance carriers and Texas Medicaid when appropriate as payment in full. The client cannot be held liable for any balance or copays related to Medicaid-covered services.*

6.12.1 Other Insurance Credits

Providing other insurance payment information, even when no additional payment is expected from TMHP, provides benefit to all parties involved in Texas Medicaid. When a TPR issues a payment or partial payment to a provider, the other insurance credit *must* be indicated on the claim form submitted to TMHP.

This procedure benefits both providers and TMHP even if the TPR payment exceeds the Medicaid allowed amount. Although additional payment may not be issued by TMHP, informing TMHP of the other insurance credit allows TMHP to track the appropriate use of TPRs. Informing TMHP of a TPR credit provides hospitals with a more accurate standard dollar amount (SDA) rate setting and assists the program in tracking recoveries and reducing Medicaid medical expenditures by informing TMHP of liable third parties.

Providers must report TPR payments correctly in the appropriate electronic field or the paper claim form block.

Claim Form	Reference
CMS-1500	Block 29, CMS-1500 Blank Claim Form (subsection 6.5.3 in this section)
UB-04 CMS-1450	Block 54, UB-04 CMS-1450 Blank Claim Form (subsection 6.6.3 in this section)
THSteps Dental	Block 31, 2006 ADA Dental Claim Form (subsection 6.7.3 in this section)

6.12.1.1 Deductibles

TMHP will consider deductibles for reimbursement when the original third party payor applied the payment amount directly to the clients deductible. The explanation of benefit reflecting the application of the payment by the other insurance (third party payor) and a completed signed claim copy must be submitted to TMHP for consideration.

6.12.1.2 HMO Copayments

TMHP processes and pays HMO copayments for private and Medicare HMOs as well as private and Medicare PPO copayments for clients who are eligible for reimbursement under Medicaid guidelines.

TMHP pays the copayment in addition to the service the HMO or PPO has denied, if the client is eligible for the Texas Medicaid Program and the procedure is reimbursed under Medicaid guidelines. Providers are not allowed to hold the client liable for the copayment.

An office or emergency room (ER) visit (the ER physician is paid only when the ER is not staffed by the hospital) is reimbursed a maximum copayment of $10 per visit. The hospital ER visit is reimbursed at a maximum of $50 to the facility. TMHP pays up to four copayments per day, per client. ER visits are limited to one per day, per client, and are considered one of the four copayments allowed per day.

Important: *By accepting assignment on a claim for which the client has Medicaid coverage, providers agree to accept payment made by insurance carriers and the Texas Medicaid Program when appropriate as payment in full. The client cannot be held liable for any balance related to Medicaid-covered services.*

The following Medicaid codes have been created for copayments, which are considered an atypical service:

POS 1 – Office	Description
CP001	Private HMO copayment—professional
CP002	Private PPO copayment—professional
CP003	Medicare HMO copayment-professional
CP004	Medicare PPO copayment-professional

POS 5 – Outpatient	Description
CP005	Private HMO copayment—outpatient
CP006	Private PPO copayment—outpatient
CP007	Medicare HMO copayment-outpatient
CP008	Medicare PPO copayment-outpatient

6.12.1.3 Verbal Denial

Providers may call the other insurance resource and receive a verbal denial. The other insurance record can either be updated when the provider files the claim or calls the TPR Customer Service at 1-800-846-7307. When calling TPR Customer Service line and when filing claims to TMHP, the provider must have the following information before any updates are made.

Verbal denial requirements:

- Date of the telephone call to the other insurance resource
- Insurance company's name and telephone number
- Name of the individual contacted at the insurance company
- Policyholder and group information for the client

- Specific reason for the denial, including the client's type of coverage to enhance the accuracy of future claims processing (for example, a policy that covers inpatient services or physician services only)

Providers that update a client's insurance records through the TMHP TPR Customer Service line must follow the current appeal process once the other insurance information has been updated on the client's file.

6.12.1.4 110-Day Rule

When a service is billed to a third party and no response has been received, Medicaid providers must allow 110 days to elapse before submitting a claim to TMHP. If a TPR has not responded or delays payment or denial of a provider's claim for more than 110 days after the date the claim was billed, Medicaid considers the claim for reimbursement. However, the 365-day federal filing deadline requirement must still be met. The following information is required:

- Name and address of the TPR
- Date the TPR was billed (used to calculate filing deadline)
- Statement signed and dated by the provider that no disposition has been received from the TPR within 110 days of the date the claim was billed

When TMHP denies a claim because of the client's other coverage, information that identifies the other insurance appears on the provider's R&S Report. The claim is not to be refiled with TMHP until disposition from the TPR has been received or until 110 days have lapsed since the billing of the claim with no disposition from the TPR. A statement from the client or family member which indicates that they no longer have this resource is *not* sufficient documentation to reprocess the claim.

When a provider is advised by a TPR that benefits have been paid to the client, the information must be included on the claim with the date and amount of payment made to the client if available. If a denial was sent to the client, refer to the verbal denial guidelines above for required information. This enables TMHP to consider the claim for reimbursement.

6.12.1.5 Filing Deadlines

In accordance with federal regulations, all claims must initially be filed with TMHP within 365 days of the DOS. Claims that involve filing to a TPR have the following deadlines:

- Claims with a valid disposition (payment or denial) must be received by TMHP within 95 days of the date of disposition by the TPR and within 365 days of the DOS. Appealed claims that were originally denied with EOB 00260, which indicates that the provider files with a TPR, must be received within 95 days of the date of disposition by the TPR or within 120 days of the date on which TMHP denied the claim.
    - The provider must appeal the claim to TMHP with complete other insurance information, which includes all EOBs and disposition dates. The disposition date is the date on which the other insurance company processed the payment or denial.
    - If a provider submits other insurance EOBs without disposition dates, the appeal will be denied. If the other insurance disposition date appears only on the first page of an EOB that has multiple pages and the claim that is being submitted to TMHP is on a subsequent page or pages, the provider must submit the first page that shows the disposition date and all of the pages that show the claim that is being submitted to TMHP.
- If more than 110 days have passed from the date a claim was filed to the TPR without a response, the claim is submitted to TMHP for consideration of payment.

Refer to: Subsection 4.11, "Third Party Resources (TPR)" in Section 4, Client Eligibility (*Vol. 1, General Information*).

6.12.2 Claims Forward to Other Insurance Carriers

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's TPR or other insurance. Providers are required to submit clients' known other insurance to TMHP.

TMHP forwards electronic institutional claims for clients suspected of having other insurance to a contractor. The contractor researches the claims to determine the client's possible other insurance information. If it is determined that the client has valid other insurance for the claim's date of service and the insurance carrier is listed below, the contractor will forward the claim to the selected insurance carrier. TMHP has begun forwarding claims to the major insurance carriers for Texas.

Provider will receive a denial EOB from TMHP on the R&S Report that will indicate that the claim was forwarded to the client's other insurance carrier.

If the other insurance carrier denies the claim, the provider should first exhaust all avenues to appeal the claim with the other insurance carrier. If the final disposition is a denial, the provider may appeal the claim to TMHP using the carrier's EOB showing the denial. Providers must review their R&S Reports to ensure that any follow-up action is taken within the appeal deadlines.

TMHP will not forward the following claim types to the contractor:

- Electronic institutional claims that are rejected by TMHP
- Electronic institutional Texas Medicaid fee-for-service and Primary Care Case Management (PCCM) adjustments
- Suspended or finalized claims
- Claims that are part of mass adjustments originating from TMHP
- All other electronic claim types (professional and dental)

  Note: *Other claim types (professional and dental) will be eligible for forwarding at a later date.*
- All Medicare crossover claims
- All NPI contingent claims
- All paper claims
- School Health and Related Services (SHARS) claims
- Early Childhood Intervention (ECI) claims
- Children with Special Health Care Needs (CSHCN) Services Program claims
- County Indigent Health Care Program (CIHCP) claims
- PCS claims
- Children and Pregnant Women (CPW) claims
- Claims that are rejected by the Contractor for HIPAA validation failures
- THSteps medical and dental claims

Refer to: Subsection 4.11, "Third Party Resources (TPR)" in Section 4, Client Eligibility (*Vol. 1, General Information*) for information about filing claims for clients with other insurance.

Section 6.12.1.5, "Filing Deadlines" in this handbook for information about filing deadlines for clients with other insurance.

6.13 Medicare Claims

When a service is a benefit of Medicare and Medicaid, the claims must be filed with Medicare first. Providers should not file a claim with Medicaid until Medicare has dispositioned the claim. The payment received from Medicare and the coinsurance or deductible payment from Medicaid must be considered payment in full. Medicaid pays the beneficiary's Part A and B deductibles and coinsurance liabilities on valid Medicare claims. These guidelines exclude clients living in a nursing facility.

Providers must accept Medicare assignment to received coinsurance and deductible amounts from Medicaid services provided to clients. If a provider has accepted a Medicare assignment, the provider may receive payment of the Medicare deductible and coinsurance from TMHP on behalf of the qualified Medicare beneficiary (QMB) or Medicaid qualified Medicare beneficiary (MQMB) client.

Providers accepting Medicare or Medicaid assignment cannot legally require the client to pay the Medicare coinsurance or deductible amounts.

Medicare primary claims filed to Medicare Administrative Contractors (MACs) may be transferred electronically to TMHP through a Coordination of Benefits Contractor (COBC) for claims processed as assigned. Providers should contact their MAC for more information. This benefit allows providers to receive disposition from both carriers while only filing the claim once. Providers allow 60 days from the date of Medicare's disposition for a claim to be shown on the Medicaid R&S Report. Claims totally denied by Medicare are not automatically transferred to TMHP.

For crossover claims that are not transferred electronically, providers must submit a paper claim to TMHP.

Refer to: Subsection 2.6, "Medicare Crossover Reimbursement" in Section 2, Texas Medicaid Reimbursement (*Vol. 1, General Information*).

6.13.1 Medicare Advantage Plans (MAPs) Claims

TMHP processes certain claims for clients enrolled in a MAP for Medicare Qualified Medicaid Beneficiary (MQMB) clients.

TMHP considers a claim for reimbursement for services that are a benefit of Texas Medicaid if claims are denied by the MAP for not a benefit or services exceed benefit limitations

Claims must first be submitted to the MAP. If the MAP issues a denial that indicates "not a benefit" or "exceeds benefit limitations," the claim can be submitted to TMHP with a copy of the MAP explanation of benefits (EOB) attached.

Note: *TMHP will not process claims that were denied by the MAP for reasons other than "not a benefit" or "exceeds benefit limitations."*

6.13.1.1 Copayments:

Claims for Medicare copayments can also be submitted to TMHP. Refer to: Sub-section 5.11.1.2" HMO Copayments" in this section for additional information.

6.13.1.2 Coinsurance and Deductible Claims

Some MAPs have contracted with HHSC to receive a monthly payment for each client the MAP enrolls. HHSC's payments to these MAPs include all Medicaid costs associated with serving MQMB clients.

A list of MAPs that are contracted with HHSC is available in the EDI section of the TMHP website at www.tmhp.com. The list will be updated as additional plans receive approved contracts.

6.13.2 Medicare/Medicaid Filing Deadlines

TMHP Standardized MRAN forms, paper MRANs from Medicare or a Medicare intermediary or computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services must be received by TMHP within 95 days of the Medicare

date of disposition in order to be considered for processing. Providers may also submit Medicare adjusted claims by submitting the adjusted computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services or paper adjusted MRAN received by Medicare or a Medicare intermediary.

Refer to: Subsection 2.6, "Claims Filing and Reimbursement", (Volume 2, Hospital Handbook) for additional information on Hospital Medicare claims filing requirements.

6.14 Filing Medicare Primary Paper Claims

Providers are allowed to file Medicare primary paper claims to TMHP for payment of coinsurance or deductible for claims that fail to cross over from Medicare electronically.

Providers that receive paper MRANs from Medicare or a Medicare intermediary or MRANs using the CMS-approved software MREP, for professional services, or PC-Print, for institutional services, may submit these MRAN to TMHP. Providers that submit these MRANs are not required to submit the TMHP Standardized MRAN Form.

Providers that cannot retrieve the MRAN from MREP or PC-Print, or who don't receive a paper MRAN from Medicare or a Medicare intermediary, must submit the TMHP Standardized MRAN Form.

Providers that submit paper crossover claims must submit only one of the approved MRAN formats—MREP, PC-Print, paper MRAN from Medicare or a Medicare intermediary or TMHP Standardized MRAN form along with a completed claim form. Paper crossover claims that contain multiple MRAN forms with conflicting information are returned to the provider or denied.

6.14.1 Crossover Claim Type 30 TMHP Standardized MRAN Form

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Revised Crossover Claim Type 30
TMHP Standardized Medicare Remittance Advice Notice Form

1	NPI/API												
2	Medicare ID												
3	TPI												
4	Provider Name												
5	Medicaid Client Number												
6	Client Last Name												
7	Client First Name												
8	Medicare Paid Date												
9	Medicare ICN												
10	Patient HIC Number												
11	Detail(s) Information	From DOS	To DOS	POS	Units	CPT	Mods	Charges	Allow	Ded	Coins	Paid	Reason Code
12	Totals Information							Charges	Allow	Ded	Coins	Paid	Reason Code
13	Medicare Prev Paid												

Effective 03192007 - Revised 05312007

6.14.2 Crossover Claim Type 30 Instructions

Providers who bill professional services on the CMS-1500 paper claim form may submit the Crossover Claim Type 30 template with a copy of a completed claim form. All fields (excluding Medicaid information fields) on the form must be completed using the Remittance Advice or Remittance Notice received from Medicare. In addition, all details from the Medicare Remittance Advice/Remittance Notice must be included in the template, regardless if a deductible or coinsurance is due.

The TMHP Standardized MRAN Form must be typed or computer-generated. Handwritten TMHP Standardized MRAN Forms will not be accepted and will be returned to the provider.

The following are the requirements for the Crossover Claim Type 30 template:

Block No.	Field Description	Guidelines
1	NPI/API	Enter the NPI for the billing provider.
2	Medicare ID	Enter the Medicare Provider ID number of the billing provider listed on the Medicare Remittance Advice/Remittance Notice.
3	TPI	Enter the Medicaid TPI number of the billing provider.
4	Provider Name	Enter the billing provider's name.
5	Medicaid Client Number	Enter the patient's nine-digit Medicaid number from their Medicaid Identification form.
6	Client Last Name	Enter the patient's last name listed on the Medicare Remittance Advice/Remittance Notice.
7	Client First Name	Enter the patient's first name listed on the Medicare Remittance Advice/Remittance Notice.
8	Medicare Paid Date	Enter the Medicare Paid Date listed on the Medicare Remittance Advice/Remittance Notice.
9	Medicare ICN	Enter the Medicare ICN number listed on the Medicare Remittance Advice/Remittance Notice.
10	Patient HIC Number	Enter the patient's Medicare HIC number (Medicare Identification number) listed on the Medicare Remittance Advice/Remittance Notice.
11	From DOS	Enter the first date of service for each procedure in a MM/DD/YYYY format.
11	To DOS	Enter the last date of service for each procedure in a MM/DD/YYYY format.
11	POS	Enter the place of service (POS) listed on the Medicare Remittance Advice/Remittance Notice.
11	Units	Enter the number of units (quantity billed) from the Medicare Remittance Advice/Remittance Notice.

Block No.	Field Description	Guidelines
11	CPT	Enter the appropriate procedure code for each procedure/service listed on the Medicare Remittance Advice/Remittance Notice. ***Note:*** *Procedure code listed on the Standardized MRAN form may not match the procedure code listed on the claim form attached.*
11	Mods	Enter the modifier (when applicable) listed on the Medicare Remittance Advice/Remittance Notice for each detail.
11	Charges	Enter the Medicare charges (billed amount) listed on the Medicare Remittance Advice/Remittance Notice for each detail.
11	Allow	Enter the Medicare allowed amount listed on the Medicare Remittance Advice/Remittance Notice for each detail.
11	Ded	Enter the Medicare deductible amount listed on the Medicare Remittance Advice/Remittance Notice for each detail.
11	Coins	Enter the Medicare Coinsurance amount listed on the Medicare Remittance Advice/Remittance Notice for each detail.
11	Paid	Enter the Medicare paid amount listed on the Medicare Remittance Advice/Remittance Notice for each detail.
11	Reason Code	Enter Medicare's reason code listed on the Medicare Remittance Advice/Remittance Notice for each detail.
12	Total Charges	Enter the Medicare total charges (billed amount) listed on the Medicare Remittance Advice/Remittance Notice. ***Note:*** *A provider may attach additional template forms (pages) as necessary. The combined total charges for all pages should be listed on the last page. All other forms must indicate "Continue" in this block.*
12	Total Allow	Enter the Medicare total allowed amount listed on the Medicare Remittance Advice/Remittance Notice.
12	Total Ded	Enter the Medicare total deductible amount listed on the Medicare Remittance Advice/Remittance Notice.
12	Total Coins	Enter the Medicare total coinsurance amount listed on the Medicare Remittance Advice/Remittance Notice.
12	Total Paid	Enter the Medicare total paid amount listed on the Medicare Remittance Advice/Remittance Notice.

Block No.	Field Description	Guidelines
12	Total Reason Code	This field must be left blank.
13	Medicare Prev Paid	Enter the Medicare previous paid amount listed on the Medicare Remittance Advice/Remittance Notice.

6.14.3 Crossover Claim Types 31 and 50

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Crossover Claim Types 31 and 50
TMHP Standardized Medicare Remittance Advice Notice Form

Medicare Paid Date:		
Provider Name:	**NPI/API/TPI:**	**Medicare ID:**
Street Address:		
City:	**State:**	**ZIP:**

Bill Type	
From DOS	
Through DOS	
Patient Last Name	
Patient First Name	
Medicare HIC	
Medicare ICN	
Total Charges	
Covered Charges	
Non Covered Charges/Reason Code	
DRG Amount	
Deductible	
Blood Deductible	
Coinsurance	
Medicare Paid Amount	
DRG Code	

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6.14.4 Crossover Claim Types 31 and 50 Instructions

Providers who bill inpatient and outpatient crossover claims on a UB-04 CMS-1450 paper claim form may submit the Crossover Claim Types 31 and 50 template with a copy of a completed claim form. All fields (excluding Medicaid information fields) on the form must be completed using the Remittance Advice or Remittance Notice received from Medicare, regardless if a deductible or coinsurance is due.

The TMHP Standardized MRAN Form must be typed or computer-generated. Handwritten TMHP Standardized MRAN Forms will not be accepted and will be returned to the provider.

The following are the requirements for the Crossover Claim Types 31 and 50 template:

Field Description	Guidelines
Medicare Paid Date	Enter the Medicare Paid Date listed on the Medicare Remittance Advice/Remittance Notice.
Provider Name	Enter the billing provider's name.
NPI/API/TPI	Enter the NPI/API/TPI for the billing provider. ***Note:*** *NPI/TPI or API/TPI.*
Medicare ID	Enter the Medicare Provider ID of the billing provider number listed on the Medicare Remittance Advice/Remittance Notice.
Street Address	Enter the billing provider's street address.
City	Enter the billing provider's city.
State	Enter the billing provider's state.
ZIP	Enter the billing provider's ZIP Code.
Bill Type	Enter the Medicare Bill Type listed on the Medicare Remittance Advice/Remittance Notice. ***Note:*** *The Medicare Bill Type may not match the TOB listed on the claim form.*
From DOS	Enter the first date of service for all procedures in a MM/DD/YYYY format.
Through DOS	Enter the last date of service for all procedures in a MM/DD/YYYY format.
Patient Last Name	Enter the patient's last name listed on the Medicare Remittance Advice/Remittance Notice.
Patient First Name	Enter the patient's first name listed on the Medicare Remittance Advice/Remittance Notice.
Medicare HIC	Enter the patient's Medicare HIC number (Medicare Identification number) listed on the Medicare Remittance Advice/Remittance Notice.
Medicare ICN	Enter the Medicare ICN number listed on the Medicare Remittance Advice/Remittance Notice.

Field Description	Guidelines
Total Charges	Enter the Medicare total charges (billed amount) listed on the Medicare Remittance Advice/Remittance Notice.
Covered Charges	Enter the covered charges listed on the Medicare Remittance Advice/Remittance Notice.
Non Covered Charges/Reason Code	Enter the non covered charges listed on the Medicare Remittance Advice/Remittance Notice followed by the reason code listed on the Medicare Remittance Advice/Remittance Notice.
DRG Amount	Enter the DRG amount listed on the Medicare Remittance Advice/Remittance Notice for inpatient claims, if applicable. ***Note:*** *Outpatient claims do not require a DRG amount.*
Deductible	Enter the Medicare deductible amount listed on the Medicare Remittance Advice/Remittance Notice.
Blood Deductible	Enter the blood deductible listed on the Medicare Remittance Advice/Remittance Notice for inpatient claims, if applicable. ***Note:*** *Outpatient claims do not require a blood deductible amount.*
Coinsurance	Enter the Medicare coinsurance amount listed on the Medicare Remittance Advice/Remittance Notice.
Medicare Paid Amount	Enter the Medicare paid amount listed on the Medicare Remittance Advice/Remittance Notice.
DRG Code	Enter the DRG code listed on the Medicare Remittance Advice/Remittance Notice for inpatient claims, if applicable. ***Note:*** *Outpatient claims do not require a DRG code.*

6.14.5 Filing a Medicare-Denied Claim

Claims denied by Medicare because the services are not a benefit of the Medicare program or because Medicare benefits have been exhausted can be submitted to TMHP for MQMB clients.

The Medicare EOB that contains the relevant claim denial must be submitted to TMHP with the completed claim from within 95 days from the Medicare disposition date and 365 days from the date of service. These claims will be processed as Medicaid-only claims.

Exception: *Claims that are denied by Medicare for administrative reasons must be appealed to Medicare before they are submitted to Texas Medicaid.*

6.14.6 Filing a Medicare-Adjusted Claim

Providers should use an adjusted Medicare Remittance Advice or Remittance Notice and complete a TMHP Standardized MRAN to submit a Medicare-adjusted claim. Providers must ensure that the information on the Medicare Remittance Advice or Remittance Notice matches the information submitted on the TMHP Standardized MRAN form and attach a completed claim form.

Providers can also submit Medicare-adjusted claims using the paper MRAN received from Medicare or a Medicare intermediary or the adjusted computer generated MRANs from the CMS-approved software applications MREP for professional services or PC--Print for institutional services.

6.15 Medically Needy Claims Filing

TMHP must receive claims for unpaid bills not applied toward spend down within 95 days from the date eligibility was added to the TMHP client eligibility file (add date). These bills must be on the appropriate claim form (for example, CMS-1500 or UB-04 CMS-1450). Providers are allowed to submit completed CMS claim forms directly to the Medically Needy Clearinghouse (MNC) or to applicants for the Medically Needy Program (MNP) to be used to meet spend down. The completed CMS claim forms used to meet spend down are held for ten calendar days by the MNC, then forwarded to TMHP claims processing. Claims for services provided after the spend down is met must be received within 95 days from the date eligibility is added. Inpatient hospital facility claims must be received within 95 days from the date of discharge or last DOS on the claim. This applies when eligibility is not retroactive.

The client's payment responsibilities are as follows:

- If the entire bill was used to meet spend down, the client is responsible for payment of the entire bill.
- If a portion of one of the bills was used to meet the spend down, the client is responsible for paying the portion applied toward the spend down, unless it exceeds the Medicaid allowable amount.
- The claim must show the *total* billed amount for the services provided. Charges for ineligible days or spend down amounts should *not* be deducted or noncovered on the claim.
- A client's payment toward spend down is *not* reflected on the claim submitted to TMHP.
- A client is not required to pay the spend down amount before a claim is filed to Medicaid.
- Payments made by the client for services not used in the spend down but were incurred during an eligible period must be reimbursed to the client before the provider files a claim to TMHP.
- Services that require prior authorization and are provided before the client becomes eligible for Medicaid by meeting spend down are not reimbursable by Texas Medicaid.
- If a bill or a completed CMS claim form was not used to meet spend down and the dates of service are within the client's eligible period, submit the total bill to TMHP.

When eligibility has been established, a TP 55 with spend down client can receive the same care and services available to all other Medicaid clients. If eligibility is established through TP 30 with spend down, the client's Medicaid eligibility is restricted to coverage for an emergency medical condition only. Emergency medical condition is defined under Emergency medical condition is defined under Subsection 4.4.2.2, "Exceptions to Limited Status" in Section 4, Client Eligibility (*Vol. 1, General Information*).

6.16 Claims for Medicaid Hospice Clients Not Related to the Terminal Illness

When the services are unrelated to the terminal illness, providers must submit a claim for Medicaid services to TMHP. The claim must include a statement and documentation from the hospice that the services billed are not related to the client's terminal illness.

If TMHP denies the claim, providers must send an appeal with the following information:

- A copy of the R&S Report, with the client or claim number in question circled
- Clinical records, which may be obtained from the hospice provider
- Supporting documentation giving reasons the services billed are not related to the terminal illness

6.16.1 Medical Services When Client is Discharged From Hospice

Submit claims to TMHP for Medicaid services with a statement that the services billed were provided after the client was discharged from the Hospice Program. The provider must obtain a copy of Form 3071, Medicaid Hospice Cancellation, from the Hospice Program to support the discharge.

If TMHP denies the claim, the provider may appeal the decision with the following information:

- A copy of the R&S Report, with the client or claim number in question circled
- Supporting documentation stating that the client was not in hospice at the time

6.16.2 Claims Address for Medicaid Hospice Clients Not Related to the Terminal Illness

Mail paper claims to the following address:

Texas Medicaid & Healthcare Partnership
PO Box 200105
Austin, TX 78720-0105

Appeal claims by writing to the following address:

Texas Medicaid & Healthcare Partnership
PO Box 200645
Austin, TX 78720-0645

6.16.3 Lab and X-Ray

Submit claims for services unrelated to the terminal illness to TMHP. Submit claims for services related to the terminal illness to the hospice provider.

6.17 Children's Health Insurance Program (CHIP) Perinatal Claims

Inpatient services under CHIP Perinatal for unborn children and women between zero and 185 percent of the federal poverty level (FPL) will be reimbursed as follows:

For women with income at or below 185 percent FPL:

- Hospital facility charges paid through Emergency Medicaid and processed by TMHP.
- Professional service charges paid and processed through CHIP.

Note: *Delivery-related professional services claims denied by the CHIP Perinatal health plan will be considered for reimbursement through Emergency Medicaid and will require the CHIP Perinatal health plan denial notice. These claims should be submitted through the existing Medicaid appeals process within 95 days from the date of the CHIP Perinatal Health plan denial notice. The provider must provide a copy of the complete explanation of benefits that includes the complete description of the reason for denial.*

For newborns with a family income at or below 185 percent FPL:

- Hospital facility charges paid through the CHIP Perinatal Program and processed by TMHP.
- Professional service charges are paid and processed through CHIP.

Inpatient services (limited to labor with delivery) for unborn children and women with income between 186 and 200 percent of FPL will be covered under CHIP Perinatal, and these claims will be paid by the CHIP Perinatal health plan.

6.17.1 CHIP Perinatal Newborn Transfer Hospital Claims

TMHP processes CHIP Perinatal newborn transfer hospital claims even if the claim from the initial hospital stay has not been received.

The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay. This change applies only to CHIP Perinatal newborns with a family income at or below 185 percent of the FPL.

Transfer claims must be filed with TMHP on an electronic institutional claim or the UB-04 CMS-1450 paper claim form using admission type 1, 2, 3, or 5 in block 14, source of admission code 4 or 6 in block 15, and the actual date and time the client was admitted in block 12 of the UB-04 CMS-1450 claim form.

6.18 Forms

6.1 Sample Letter XUB Computer Billing Service Inc

XUB Computer Billing Service, Inc.
4040 Main Street
Anytown, USA 11111

Dear Sir:

This letter authorizes the XUB Computer Billing Service, Inc. to use my signature and to attest on my behalf to the requirements authorized in the following paragraphs, when submitting Medicaid claims on my behalf.

This is also to certify that information appearing on billings submitted by me for the Texas Medical Assistance Program is and will be true, accurate, and complete. I understand that payment of any Texas Medical Assistance Program claim will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. These certifications are made in accordance with requirements found at 42 Code Federal Regulations 455.18 and 455.19.

I also certify that the items billed to the Texas Medical Assistance Program are and will be for services that have been and will be personally provided by me or under my personal direction, and in cases of physician services, the services, supplies, or other items billed have been and will be medically necessary for the diagnosis or treatment of the condition of the patients, and are provided without regard to race, color, sex, national origin, age, or handicap.

Additionally, I agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the Texas Medical Assistance Program. I also agree to furnish them at no cost and provide access to information regarding any payments claimed for providing such services as the State Agency, Attorney General's Office, and Department of Health and Human Services (HHS) Office may request for five years from date of service (6 years for freestanding rural health clinic; 10 years for hospital-based rural health clinic), or until any dispute is settled, whichever occurs first.

I agree to accept the amounts paid by the Medicaid Program as full payment for the services rendered for which a Medicaid benefit is provided under the Texas Medical Assistance Program.

This letter, to be retained in your files, bears my true and original signature:

_____/_____/_____
Provider Signature Date

_____ _____
TPI NPI

Effective Date_01152008/Revised Date_08082007