# Table of Contents

1. **General Information** ................................................................. CH-15
   1.1 Medical Transportation Program .................................................. CH-15

2. Chemical Dependency Treatment Facility Services .................................. CH-15
   2.1 Overview .................................................................................. CH-15
   2.2 Enrollment ................................................................................. CH-15
   2.3 Services/Benefits, Limitations, and Prior Authorization ......................... CH-16
      2.3.1 Outpatient Counseling .......................................................... CH-16
      2.3.2 Prior Authorization .............................................................. CH-17
   2.4 Documentation Requirements ....................................................... CH-17
   2.5 Claims Filing and Reimbursement .................................................. CH-17
      2.5.1 Claims Information .............................................................. CH-17
      2.5.2 Reimbursement ................................................................. CH-18

3. Medicaid Children’s Services (CCP) .................................................. CH-18
   3.1 Early Childhood Intervention (ECI) (CCP) ......................................... CH-18
   3.2 CCP Overview ........................................................................... CH-19
      3.2.1 Client Eligibility ................................................................. CH-19
      3.2.2 Enrollment .......................................................................... CH-19
      3.2.3 Services/Benefits and Limitations ............................................. CH-20
      3.2.4 Prior Authorization and Documentation Requirements .................. CH-21
         3.2.4.1 Diagnosis Coding ........................................................ CH-22
         3.2.4.2 Drug and Medical Device Approval .................................. CH-22
         3.2.4.3 Physician Signature ....................................................... CH-22
      3.2.5 Claims Filing and Reimbursement ............................................ CH-22
         3.2.5.1 Claims Information ....................................................... CH-22
         3.2.5.2 Reimbursement ............................................................ CH-23
   3.3 Clinician-Directed Care Coordination Services (CCP) ......................... CH-22
      3.3.1 Services/Benefits and Limitations ............................................. CH-22
         3.3.1.1 Non-Face-to-Face Services ............................................. CH-24
            3.3.1.1.1 Non-Face-to-Face Medical Conferences ..................... CH-24
            3.3.1.1.2 Non-Face-to-Face Clinician Supervision of a Home Health Client CH-24
            3.3.1.1.3 Non-Face-to-Face Clinician Supervision of a Hospice Client ........ CH-24
            3.3.1.1.4 Non-Face-to-Face Clinician Supervision of a Facilities Client ........ CH-24
            3.3.1.1.5 Other Non-Face-to-Face Supervision .......................... CH-24
            3.3.1.1.6 Non-Face-to-Face Prolonged Services ......................... CH-25
            3.3.1.1.7 Non-Face-to-Face Specialist or Subspecialist Telephone Consultation .... CH-25
            3.3.1.1.8 General Requirements for Non-Face-to-Face Clinician-Directed Care Coordination Services ............................................... CH-26
            3.3.1.1.9 Non-Face-to-Face Care Plan Oversight .......................... CH-26
            3.3.1.1.10 Medical Team Conference ........................................ CH-26
         3.3.1.2 Face-to-Face Services ....................................................... CH-27
            3.3.1.2.1 General Requirements for Face-to-Face Clinician-Directed Care Coordination Services ................................................... CH-27
      3.3.2 Prior Authorization and Documentation Requirements .................. CH-27
         3.3.2.1 Documentation Requirements for the Medical Home Clinician for a Telephone Consult with a Specialist ........................................ CH-29
         3.3.2.2 Documentation Requirements for the Specialist or Subspecialist for a Telephone Consult with the Medical Home Clinician ................ CH-29

---

**CHILDREN’S SERVICES HANDBOOK**
3.4 Comprehensive Outpatient Rehabilitation Facilities (CORFs)/Outpatient Rehabilitation Facilities (ORFs) ..................................................CH-30
3.4.1 Enrollment ..................................................................................CH-30
3.4.2 Services/Benefits and Limitations ..................................................CH-30
3.4.3 Prior Authorization and Documentation Requirements ..................CH-32
3.4.4 Claims Information .....................................................................CH-33
3.4.5 Reimbursement ...........................................................................CH-33

3.5 Durable Medical Equipment (DME) Supplier (CCP) ..........................CH-33
3.5.1 Enrollment ..................................................................................CH-33
3.5.1.1 Pharmacies (CCP) .................................................................CH-33
3.5.2 Services/Benefits and Limitations ..................................................CH-34
3.5.2.1 Purchase Versus Equipment Rental ............................................CH-35
3.5.3 Prior Authorization and Documentation Requirements .................CH-36
3.5.3.1 Equipment Accessories .........................................................CH-36
3.5.3.2 Equipment Modifications .......................................................CH-36
3.5.3.3 Equipment Adjustments ........................................................CH-36
3.5.3.4 Equipment Repairs ...............................................................CH-37
3.5.3.5 DME Certification and Receipt Form ........................................CH-37
3.5.3.6 Specific CCP Policies ............................................................CH-37
3.5.4 Cardiorespiratory (Apnea) Monitor .................................................CH-38
3.5.4.1 Services/Benefits and Limitations .............................................CH-38
3.5.4.2 Prior Authorization and Documentation Requirements ...............CH-38
3.5.5 Croup Tent/Pulse Oximeter ........................................................CH-39
3.5.5.1 Services/Benefits and Limitations .............................................CH-39
3.5.5.1.1 Croup Tent ..................................................................CH-39
3.5.5.1.2 Pulse Oximeter ...............................................................CH-39
3.5.5.2 Prior Authorization and Documentation Requirements ................CH-39
3.5.5.2.1 Croup Tent ..................................................................CH-39
3.5.5.2.2 Pulse Oximeter ...............................................................CH-39
3.5.6 Donor Human Milk ....................................................................CH-41
3.5.6.1 Services/Benefits and Limitations .............................................CH-41
3.5.6.2 Prior Authorization and Documentation Requirements ...............CH-41
3.5.7 Electronic Blood Pressure Monitoring Device .................................CH-42
3.5.7.1 Services/Benefits and Limitations .............................................CH-42
3.5.7.2 Prior Authorization and Documentation Requirements ................CH-43
3.5.8 Incontinence Supplies for Clients Who Are Birth Through 3 Years of Age ....CH-43
3.5.8.1 Services/Benefits and Limitations .............................................CH-43
3.5.8.2 Prior Authorization and Documentation Requirements ...............CH-44
3.5.9 Medical Nutritional Products .....................................................CH-44
3.5.9.1 Services/Benefits and Limitations .............................................CH-44
3.5.9.1.1 Enteral Nutritional Products ..............................................CH-45
3.5.9.2 Prior Authorization and Documentation Requirements ...............CH-45
3.5.10 Mobility Aids .........................................................................CH-46
3.5.10.1 Services/Benefits and Limitations .............................................CH-46
3.5.10.1.1 Portable Client Lifts for Outside the Home Setting .................CH-46
3.5.10.1.2 Strollers (a multipositional client transfer system with integrated seat, operated by care giver) ..............................................CH-46
3.5.10.1.3 Stroller Ramps—Portable and Threshold ..............................CH-47
3.5.10.1.4 Feeder Seats, Floor Sitters, Corner Chairs, and Travel Chairs ....CH-47
3.6 Medical Nutrition Counseling Services (CCP) ...........................................CH-54
3.6.1 Enrollment ......................................................CH-54
3.6.2 Services/Benefits and Limitations ...............................CH-54
3.6.3 Prior Authorization and Documentation Requirements ..............CH-54
3.6.4 Claims Information ...........................................CH-54
3.6.5 Reimbursement ...............................................CH-54

3.7 Orthotic and Prosthetic Services (CCP) .................................CH-57
3.7.1 Enrollment ......................................................CH-57
3.7.2 Services/Benefits and Limitations ...............................CH-57
3.7.3 Prior Authorization and Documentation Requirements ..............CH-57
3.7.4 Cranial Molding Orthotics ......................................CH-59
3.7.5 Corrective Shoe, Wedge, and Lift ..............................CH-60
3.7.6 Dynamic Splint ................................................CH-61
3.7.7 Protective Helmets .............................................CH-61
3.7.10 Thoracic-Hip-Knee-Ankle Orthoses (THKAO) (Vertical or Dynamic Stander, Standing Frames/Braces, and Parapodiums) ........................................ CH-62
  3.7.10.1 Services/Benefits and Limitations ........................................ CH-62
    3.7.10.1.1 Parapodium .......................................................... CH-62
    3.7.10.1.2 Standing Frame or Brace ......................................... CH-62
    3.7.10.1.3 Vertical or Dynamic Stander ...................................... CH-62
  3.7.10.2 Prior Authorization and Documentation Requirements ............... CH-62
3.7.11 Claims Information ............................................................ CH-63
3.7.12 Reimbursement .................................................................. CH-63

3.8 Personal Care Services (PCS) (CCP) ........................................ CH-63
  3.8.1 Enrollment ....................................................................... CH-63
  3.8.2 Services/Benefits and Limitations ........................................ CH-64
    3.8.2.1 Place of Services ......................................................... CH-66
    3.8.2.2 Client Eligibility .......................................................... CH-66
      3.8.2.2.1 Accessing the PCS Benefit ......................................... CH-67
      3.8.2.2.2 The Primary Practitioner's Role in the PCS Benefit ......... CH-68
      3.8.2.3 PCS Provided in Group Settings ..................................... CH-68
  3.8.3 Prior Authorization and Documentation Requirements ................. CH-68
    3.8.3.1 PCS Provider Responsibilities ......................................... CH-69
    3.8.3.2 Documentation of Services Provided/Retrospective Review ....... CH-69
  3.8.4 Claims Information ............................................................ CH-70
  3.8.5 Reimbursement .................................................................. CH-70

3.9 Private Duty Nursing (CCP) .................................................... CH-70
  3.9.1 Enrollment ....................................................................... CH-70
  3.9.2 Services/Benefits and Limitations ........................................ CH-71
    3.9.2.1 PDN Provided During a Skilled Nursing Visit for TPN Administration Education .................................................. CH-74
    3.9.2.2 Criteria ...................................................................... CH-75
      3.9.2.2.1 Client Eligibility Criteria ........................................... CH-75
      3.9.2.2.2 Retroactive Client Eligibility ....................................... CH-75
      3.9.2.2.3 Medical Necessity ..................................................... CH-76
      3.9.2.2.4 Place of Service (POS) ................................................. CH-76
      3.9.2.2.5 Amount and Duration of PDN ..................................... CH-76
  3.9.3 Prior Authorization and Documentation Requirements .................. CH-76
    3.9.3.1 Start of Care (SOC) ....................................................... CH-78
    3.9.3.2 Prior Authorization of Initial Requests ............................... CH-78
    3.9.3.3 Authorization for Revision of Current Services ...................... CH-79
    3.9.3.4 Recertifications of Authorizations ..................................... CH-80
    3.9.3.5 Termination of Authorization .......................................... CH-80
    3.9.3.6 Client/Provider Notification ............................................ CH-81
    3.9.3.7 Authorization Appeals .................................................... CH-81
    3.9.3.8 CCP Prior Authorization Request Form .............................. CH-81
    3.9.3.9 Home Health Plan of Care (POC) ...................................... CH-81
    3.9.3.10 Nursing Addendum to Plan of Care (CCP) Form ................. CH-82
4.2 Enrollment ................................................................. CH-105
  4.2.1 SHARS Enrollment .................................................. CH-105
  4.2.2 Nonschool SHARS Provider Enrollment ......................... CH-105
  4.2.3 Private School Enrollment ......................................... CH-106
  4.2.4 Medicaid Managed Care Enrollment ................................. CH-106

4.3 Services/Benefits, Limitations, and Prior Authorization ............. CH-106
  4.3.1 Audiology .......................................................... CH-106
    4.3.1.1 Audiology Billing Table ....................................... CH-107
  4.3.2 Counseling Services .............................................. CH-107
    4.3.2.1 Counseling Services Billing Table ........................... CH-108
  4.3.3 Psychological Testing and Services .............................. CH-108
    4.3.3.1 Psychological Testing ......................................... CH-108
    4.3.3.2 Psychological Services ........................................ CH-109
  4.3.4 Nursing Services .................................................. CH-110
    4.3.4.1 Nursing Services Billing Table ............................... CH-110
  4.3.5 Occupational Therapy ............................................. CH-111
    4.3.5.1 Occupational Therapy Billing Table .......................... CH-112
  4.3.6 Personal Care Services ............................................ CH-112
    4.3.6.1 Personal Care Services Billing Table ......................... CH-113
  4.3.7 Physical Therapy .................................................. CH-113
    4.3.7.1 Physical Therapy Billing Table ............................... CH-114
  4.3.8 Physician Services ................................................ CH-114
    4.3.8.1 Medical Services Billing Table ............................... CH-115
  4.3.9 Speech Therapy ................................................... CH-115
    4.3.9.1 Referral ....................................................... CH-115
    4.3.9.2 Description of Services ....................................... CH-115
    4.3.9.3 Provider and Supervision Requirements ....................... CH-115
    4.3.9.4 Speech Therapy Billing Table ................................. CH-116
  4.3.10 Transportation Services in a School Setting ..................... CH-116
    4.3.10.1 Transportation Services in a School Setting Billing Table  CH-117
  4.3.11 Prior Authorization .............................................. CH-117

4.4 Documentation Requirements ......................................... CH-118
  4.4.1 Record Retention .................................................. CH-118

4.5 Claims Filing and Reimbursement ................................... CH-118
  4.5.1 Claims Information ................................................ CH-118
    4.5.1.1 Appealing Denied SHARS Claims ............................... CH-118
    4.5.1.2 Billing Units Based on 15 Minutes ............................ CH-119
    4.5.1.3 Billing Units Based on an Hour ............................... CH-119
  4.5.2 Reimbursement .................................................... CH-120
    4.5.2.1 Random Moment Time Study (RMTS) ............................ CH-120
    4.5.2.2 Certification of Funds ........................................ CH-121
    4.5.2.3 Cost Reporting ................................................ CH-121
    4.5.2.4 Cost Reconciliation and Cost Settlement ..................... CH-122

5. Texas Health Steps (THSteps) Dental ................................ CH-122
  5.1 Overview ............................................................ CH-122
    5.1.1 THSteps Dental Eligibility ...................................... CH-122

5.2 Enrollment ........................................................... CH-123
  5.2.1 Categories of Practice ........................................... CH-123
  5.2.2 THSteps Dental and ICF-MR Dental Services ........................ CH-124
  5.2.3 THSteps Dental Checkup and Treatment Facilities ................ CH-124
5.3 Services/Benefits, Limitations, and Prior Authorization ........................................... CH-125

5.3.1 THSteps Dental Services ...................................................... CH-125

5.3.1.1 Parental Accompaniment .................................................. CH-126

5.3.2 Comprehensive Care Program (CCP) ........................................ CH-126

5.3.3 ICF-MR Dental Services ....................................................... CH-126

5.3.3.1 THSteps and ICF-MR Provision of Dental Services ................. CH-126

5.3.3.2 Children in Foster Care .................................................... CH-127

5.3.4 Written Informed Consent and Standards of Care .......................... CH-127

5.3.5 First Dental Home ............................................................. CH-127

5.3.6 Dental Referrals by THSteps Primary Care Providers ..................... CH-128

5.3.7 Change of Provider .......................................................... CH-129

5.3.7.1 Interrupted or Incomplete Orthodontic Treatment Plans .......... CH-129

5.3.8 Periodicity for THSteps Dental Services .................................. CH-129

5.3.8.1 Exceptions to Periodicity .................................................. CH-130

5.3.9 Tooth Identification (TID) and Surface Identification (SID) Systems CH-131

5.3.9.1 Supernumerary Tooth Identification .................................... CH-131

5.3.10 Medicaid Dental Benefits, Limitations, and Fee Schedule ............ CH-132

5.3.11 Diagnostic Services .......................................................... CH-132

5.3.12 Preventive Services .......................................................... CH-136

5.3.13 Therapeutic Services ......................................................... CH-138

5.3.14 Restorative Services ........................................................ CH-139

5.3.15 Endodontics Services ....................................................... CH-142

5.3.16 Periodontal Services ........................................................ CH-144

5.3.17 Prosthodontic (Removable) Services .................................... CH-147

5.3.18 Implant Services ............................................................. CH-150

5.3.19 Prosthodontic (Fixed) Services ........................................... CH-151

5.3.20 Oral and Maxillofacial Surgery Services .................................. CH-153

5.3.21 Adjunctive General Services .............................................. CH-157

5.3.22 Dental Therapy Under General Anesthesia ............................... CH-160

5.3.22.1 Criteria for Dental Therapy Under General Anesthesia ........ CH-161

5.3.22.2 Criteria for Dental Therapy Under General Anesthesia, Attachment 1 CH-162

5.3.23 Hospitalization and ASC/HASC .......................................... CH-163

5.3.24 Orthodontic Services (THSteps) .......................................... CH-163

5.3.24.1 Benefits and Limitations ............................................... CH-164

5.3.24.2 Completion of Treatment Plan ......................................... CH-165

5.3.24.3 Premature Removal of Appliances ..................................... CH-166

5.3.24.4 Transfer of Orthodontic Services .................................... CH-166

5.3.24.5 Comprehensive Orthodontic Treatment ............................ CH-167

5.3.24.6 Orthodontic Procedure Codes and Fee Schedule ............... CH-168

5.3.25 Special Orthodontic Appliances ......................................... CH-168

5.3.26 How to Score the Handicapping Labio-lingual Deviation (HLD) Index CH-171

5.3.26.1 HLD Score Sheet .......................................................... CH-172

5.3.27 Emergency and/or Trauma Related Services for All THSteps Clients and Clients 5 Months of Age or Younger ............................ CH-173

5.3.28 Emergency Services for Medicaid Clients 21 Years of Age or Older CH-174

5.3.28.1 Long Term Care (LTC) Emergency Dental Services .............. CH-175

5.3.28.2 Laboratory Requirements .............................................. CH-175
5.4 Documentation Requirements ........................................ CH-177
  5.4.1 General Anesthesia ........................................ CH-178
  5.4.2 Orthodontic Services ........................................ CH-179

5.5 Utilization Review .................................................. CH-179

5.6 Claims Filing and Reimbursement ................................ CH-180
  5.6.1 Reimbursement ................................................ CH-180
  5.6.2 Third-Party Resources (TPR) ............................... CH-180
  5.6.3 Billing After Loss of Eligibility ........................... CH-180
  5.6.4 Claims Information ........................................ CH-180
  5.6.5 Claim Appeals ............................................. CH-181
  5.6.6 Frequently Asked Questions About Dental Claims .... CH-183

6. THSteps Medical ....................................................... CH-185

6.1 THSteps Medical and Dental Administrative Information .... CH-185
  6.1.1 Overview ..................................................... CH-185
  6.1.2 Statutory Requirements ..................................... CH-185
  6.1.3 Texas Vaccines for Children (TVFC) Program ............. CH-186
  6.1.4 Vaccine Adverse Event Reporting System (VAERS) ....... CH-186
  6.1.5 Referrals for Medicaid-Covered Services ................. CH-186
  6.1.6 THSteps Medical Checkup Facilities ....................... CH-188
  6.1.7 THSteps Dental Services .................................... CH-188
     6.1.7.1 How the THSteps Dental Program Works ............. CH-188

6.2 Enrollment ........................................................... CH-189
  6.2.1 THSteps Medical Provider Enrollment .................... CH-189
     6.2.1.1 Additional Education Requirements for Registered Nurses (RNs) CH-190
     6.2.1.2 Medicaid Managed Care Enrollment ................... CH-190

6.3 Services/Benefits, Limitations, and Prior Authorization ....... CH-191
  6.3.1 THSteps Medical Checkups .................................. CH-191
     6.3.1.1 Medical Home Concept ................................ CH-192
     6.3.1.2 Mobile Units and the Medical Home .................. CH-192
     6.3.1.3 Eligibility for a Medical Checkup .................... CH-192
     6.3.1.4 Verification of Medical Checkups ....................... CH-193
     6.3.1.5 Follow-up Medical Visit ............................... CH-193
     6.3.1.6 Exception-to-Periodicity Checkups .................... CH-193
     6.3.1.7 Medical Checkups for Infants, Children, and Adolescents (Birth Through 20 Years of Age) ................ CH-194
     6.3.1.7.1 Acute Care Visits ................................ CH-196
     6.3.1.8 Newborn Examination ................................ CH-197
     6.3.1.9 THSteps Medical Checkups Periodicity Schedule .... CH-197

6.3.2 Screening Components With Additional Requirements ........ CH-200
  6.3.2.1 Developmental Screening ................................ CH-200
  6.3.2.2 Referrals for Developmental Assessment .............. CH-201
  6.3.2.3 Mental Health ........................................... CH-201
  6.3.2.4 Sensory Screenings ...................................... CH-202
     6.3.2.4.1 Vision Screening ................................ CH-202
6.3.2.4.2 Hearing Screening……………………………………………….. CH-202
6.3.2.5 Tuberculosis Screening……………………………………………….. CH-203
6.3.2.6 Laboratory Procedures……………………………………………….. CH-204
6.3.2.6.1 Laboratory Services……………………………………………….. CH-204
6.3.2.6.2 Laboratory Supplies……………………………………………….. CH-205
6.3.2.6.3 Newborn Screening Supplies……………………………………….. CH-206
6.3.2.6.4 Laboratory Submission…………………………………………….. CH-206
6.3.2.6.5 Send Comments…………………………………………………… CH-207
6.3.2.6.6 Required Laboratory Tests Related to Medical Checkups ………… CH-207
6.3.2.6.7 Additional Required Laboratory Tests Related to Medical Checkups for Adolescents…………………………………………………….. CH-208
6.3.2.6.8 Laboratory Reporting……………………………………………….. CH-210
6.3.2.7 Administrations and Immunizations…………………………………….. CH-210
6.3.2.7.1 Vaccine Information Statement (VIS)……………………………… CH-210
6.3.2.8 Dental Screening and Intermediate Oral Evaluation with Fluoride Varnish Application in the Medical Home……………………………………….. CH-212
6.3.2.8.1 Dental Screening…………………………………………………… CH-212
6.3.2.8.2 Intermediate Oral Evaluation with Fluoride Varnish Application… CH-212
6.3.2.9 Anticipatory Guidance………………………………………………….. CH-213

6.4 Documentation Requirements……………………………………………….. CH-213
6.4.1 THSteps Medical Checkups—Documentation of Completed Checkups …… CH-213
6.4.1.0.1 Separate Identifiable Acute Care Evaluation and Management Visit… CH-214

6.5 Claims Filing and Reimbursement…………………………………………….. CH-214
6.5.1 THSteps Medical Checkups……………………………………………….. CH-215
6.5.1.1 Claims Information…………………………………………………… CH-215
6.5.1.2 Reimbursement………………………………………………………… CH-215

7. Claims Resources………………………………………………………………….. CH-216

8. Contact TMHP……………………………………………………………………….. CH-217
8.1 Automated Inquiry System (AIS)………………………………………………….. CH-217
8.2 TMHP Website…………………………………………………………………….. CH-217
8.3 (Dental) Information and Assistance…………………………………………….. CH-217
8.3.1 Dental Inquiry Line…………………………………………………………….. CH-217

8.4 (THSteps) Information and Assistance……………………………………………. CH-218
8.5 Assistance with Program………………………………………………………… CH-218

9. Forms…………………………………………………………………………………. CH-218
CH.1 CCP Prior Authorization Request Form……………………………………….. CH-219
CH.2 CCP Prior Authorization Private Duty Nursing 6-Month Authorization …….. CH-220
CH.3 CCP ECI Request for Initial/Renewal Outpatient Therapy………………….. CH-221
CH.4 DME Certification and Receipt Form (3 Pages)………………………………….. CH-222
CH.5 Donor Human Milk Request Form…………………………………………….. CH-225
CH.6 External Insulin Pump……………………………………………………………. CH-226
CH.7 Home Health Plan of Care (POC)……………………………………………….. CH-227
CH.8 Nursing Addendum to Plan of Care (CCP) (7 Pages)…………………………….. CH-228
CH.9 Psychiatric Inpatient Initial Admission Request Form…………………………….. CH-235
CH.10 Psychiatric Inpatient Extended Stay Request Form…………………………….. CH-236
CH.11 Pulse Oximeter Form…………………………………………………………….. CH-237
CH.12 Request for Initial Outpatient Therapy (Form TP-1)…………………………….. CH-238
CH.13 Request for Extension of Outpatient Therapy (Form TP-2) (2 Pages)………… CH-239
CH.14 THSteps Dental Mandatory Prior Authorization Request Form…………………… CH-241
10. Claim Form Examples

CH.21 Chemical Dependency Treatment Facility ................................................................. CH-256
CH.22 Comprehensive Outpatient Rehabilitation Facility (CORF) (CCP Only) ................ CH-257
CH.23 Diagnosis and Treatment (Referral from THSteps Checkup) .................................. CH-258
CH.24 Durable Medical Equipment (CCP Only) ................................................................. CH-259
CH.25 Early Childhood Intervention (CCP Only) ................................................................. CH-260
CH.26 Inpatient Psychiatric Hospital/Facility (CCP Only) .................................................. CH-261
CH.27 Inpatient Rehabilitation Hospital (CCP Only) .......................................................... CH-262
CH.28 Medical Nutritional Counseling (CCP Only) ........................................................... CH-263
CH.29 Occupational Therapists (CCP Only) ........................................................................ CH-264
CH.30 Orthotic and Prosthetic Services (CCP Only) ............................................................ CH-265
CH.31 Physical Therapists (CCP Only) ................................................................................ CH-266
CH.32 Private Duty Nurses (CCP Only) ................................................................................ CH-267
CH.33 School Health and Related Services (SHARS) ........................................................... CH-268
CH.34 Speech-Language Pathologists (CCP Only) ............................................................... CH-269
CH.35 THSteps New Patient, Immunization, Physical Examination by a Nurse Practitioner, and FQHC Billing ................................................................. CH-270
CH.36 THSteps Established Patient and Referral, TB Skin Test, and Physical Examination by a Physician ...................................................................................... CH-271

11. Appendices

Appendix A: THSteps Forms

A.1 Claim Forms .................................................................................................................... CH-274
A.2 Child Health Clinical Records ......................................................................................... CH-274
A.3 Guidelines for Tuberculosis Skin Testing ....................................................................... CH-274
A.4 Laboratory Forms ......................................................................................................... CH-275
CH.37 Child Health History (2 Pages). ................................................................................ CH-276
CH.38 Child Health Record (Birth–1 Month) (2 Pages) ....................................................... CH-278
CH.39 Child Health Record (2–6 Months) (2 Pages) ............................................................. CH-280
CH.40 Child Health Record (7–12 Months) (2 Pages) ......................................................... CH-282
CH.41 Child Health Record (13 Months–2 Years) (2 Pages) ............................................... CH-284
CH.42 Child Health Record (3–5 Years) (2 Pages) ............................................................... CH-286
CH.43 Child Health Record (6-10 Years) (2 Pages) ............................................................. CH-288
CH.44 Hearing Checklist for Parents ................................................................................... CH-290
CH.45 Hearing Checklist for Parents (Spanish) ................................................................. CH-291
CH.46 Mental Health Interview Tool/Referral Form (Ages 0–2 Years) .............................. CH-292
CH.47 Mental Health Interview Tool/Referral Form (Ages 3–9 Years) .............................. CH-293
CH.48 Mental Health Interview Tool/Referral Form (Ages 10–12 Years) ......................... CH-294
CH.49 Mental Health Interview Tool/Referral Form (Ages 13–20 Years) ......................... CH-295
CH.50 Mental Health Parent Questionnaire (Ages Birth–2 Years) (2 Pages) .................. CH-296
CH.51 Mental Health Questionnaire (Ages Birth–2 Years) (2 Pages) (Spanish) ............... CH-298
CH.52 Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages) ......................... CH-300
Appendix D: Texas Health Steps Statutory State Requirements

A.5 Tuberculosis Screening and Education Tool ........................................ CH-314
A.5.1 Tuberculosis Screening and Education Tool ................................. CH-315
A.5.2 Tuberculosis Screening and Education Form............................. CH-316
A.5.3 Tuberculosis Screening and Education Questionnaire ............... CH-317
A.5.4 Tuberculosis Screening and Education Questionnaire (Spanish) .CH-318
A.5.5 Tuberculosis Screening and Education Questionnaire (Spanish). .CH-319
A.5.6 Tuberculosis Screening and Education Questionnaire (Spanish) (Spanish) CH-320
A.5.7 Tuberculosis Screening and Education Questionnaire (Spanish) (Spanish) CH-321
A.5.8 Tuberculosis Screening and Education Questionnaire (Spanish) (Spanish) CH-322
A.5.9 Tuberculosis Screening and Education Questionnaire (Spanish) (Spanish) CH-323
A.5.10 Tuberculosis Screening and Education Questionnaire (Spanish) (Spanish) CH-324

Appendix C: Lead Screening

B.1 Immunizations Overview .......................................................... CH-328
B.1.1 Vaccine Adverse Event Reporting System (VAERS) .................. CH-328
B.1.2 TVFC Versus Non-TVFC Vaccines/Toxoids ............................. CH-328
B.1.3 Exemption from Immunization for School and Child-Care Facilities.CH-328
B.2 Recommended Childhood Immunization Schedule ..................... CH-329
B.2.1 Recommended Childhood and Adolescent Immunization Schedule, 2010.CH-330
B.3 General Recommendations ..................................................... CH-333
B.3.1 How to Obtain Free Vaccines ............................................... CH-333
B.3.2 Administrative Rules and Immunization Requirements ............. CH-333
B.3.2.1 Vaccine Procedure Codes and State-Defined Components ........CH-333
B.3.2.2 Requirements for TVFC Providers .................................. CH-334
B.3.4 How to Report Immunization Records to ImmTrac, the Texas Immunization Registry .................................................. CH-335
B.3.4.1 Direct Internet Entry .................................................. CH-336
B.3.4.2 Electronic Data Transfer (Import) .................................... CH-336
B.3.4.3 Obtaining Parental Consent for Registry Participation ............ CH-336
B.4 Texas Vaccines for Children Program Packet ............................... CH-336

Appendix C: Lead Screening

C.1 Blood Lead Screening Procedures and Follow-up Testing ............... CH-338
C.2 Symptoms of Lead Poisoning ..................................................... CH-338
C.3 Measuring Blood Lead Levels .................................................... CH-338
C.5 Lead Poisoning Prevention Educational Materials and Forms ........ CH-341

Appendix D: Texas Health Steps Statutory State Requirements

D.1 Legislative Requirements ......................................................... CH-344
D.2 Texas Health Steps (THSteps) Program ....................................... CH-344
D.3 Communicable Disease Reporting ............................................. CH-344
D.4 Early Childhood Intervention (ECI) Referrals ............................... CH-344
D.5 Parental Accompaniment ......................................................... CH-344
D.6 Newborn Blood Screening ....................................................... CH-345
D.7 Abuse and Neglect .................................................. CH-345
  D.7.1 Requirements for Reporting Abuse or Neglect .................. CH-345
  D.7.2 Procedures for Reporting Abuse or Neglect .................... CH-345
    D.7.2.1 Staff Training on Reporting Abuse and Neglect ............ CH-346

Appendix E: Hearing Screening Information
  E.1 Newborn Hearing (2 Pages) ..................................... CH-348
  E.2 Texas Early Hearing Detection and Intervention (TEHDI) Process .......... CH-350
    E.2.1 Birth Screen ................................................ CH-350
    E.2.2 Outpatient Rescreen ....................................... CH-350
    E.2.3 Evaluation using Texas Pediatric Protocol for Audiology ......... CH-350
    E.2.4 Referral to an ECI program ................................ CH-351
    E.2.5 Periodic Monitoring by the Physician or Medical Home .......... CH-351
  E.3 JCIH 2007 Position Statement .................................. CH-351

Appendix F: THSteps Quick Reference Guide
  F.1 Texas Health Steps Quick Reference Guide ....................... CH-354

Appendix G: THSteps Dental Guidelines
  G.1 American Academy of Pediatric Dentistry Periodicity Guidelines (9 Pages) .... CH-358
  G.2 American Dental Association Guidelines for Prescribing Dental Radiographs (3 Pages) .................. CH-367

Note: A comprehensive Index, including Volume 1 and all handbooks from Volume 2, is included at the end of Volume 1 (General Information).
CHILDREN’S SERVICES HANDBOOK

1. GENERAL INFORMATION

The information in this handbook is intended for chemical dependency treatment facilities (CDTFs), dentists, school districts, physicians, physician assistants (PAs), rural health clinics (RHCs), Federally Qualified Health Centers (FQHCs), advanced practice registered nurses (APRNs), Home Health Agencies (HHAs), durable medical equipment (DME) suppliers, hospitals, and clinics. The handbook provides information about Texas Medicaid’s benefits, policies, and procedures applicable to these providers.

Important: All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 Texas Administrative Code (TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

All providers are required to report suspected child abuse or neglect as outlined in Subsection 1.4, “Provider Responsibilities” in Section 1, Provider Enrollment and Responsibilities (Vol 1, General Information).

1.1 Medical Transportation Program

The Medical Transportation Program (MTP) is funded with federal and state dollars to arrange nonemergency transportation to medical or dental appointments for eligible clients and their attendants.

Refer to: Volume 1, Appendix D, “Medical Transportation” for more information on the Medical Transportation Program.

2. CHEMICAL DEPENDENCY TREATMENT FACILITY SERVICES

2.1 Overview

CDTF services are provided to clients experiencing a significant behavioral health issue with a diagnosis of substance abuse or dependence.

Clients may be referred to a CDTF after it has been determined through screening brief intervention that there is a need for more extensive treatment.

Refer to: Section 8, “Screening, Brief Intervention, and Referral to Treatment (SBIRT)” in the Behavioral Health, Rehabilitation, and Case Management Services Handbook (Vol. 2, Provider Handbooks) for more information on SBIRT services.

2.2 Enrollment

Only CDTFs licensed by the Department of State Health Services (DSHS) are eligible to enroll and participate in Texas Medicaid. Each facility must submit a copy of its DSHS license with the enrollment
packet. Facilities maintained or operated by the Federal government or directly operated by the state of Texas are exempt from the licensing requirement.

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

Section 8, Managed Care (Vol. 1, General Information).


### 2.3 Services/Benefits, Limitations, and Prior Authorization

#### 2.3.1 Outpatient Counseling

CDTF services must be determined by a qualified credentialed counselor (QCC) (as defined by DSHS licensure standards) to be reasonable and necessary for a person who has a diagnosis of substance abuse or dependence. Substance abuse or dependence is based on the diagnostic criteria in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Chemical dependency is defined as meeting at least three of the diagnostic criteria for psychoactive substance dependence in the current edition of the DSM.

CDTF services must be billed with the appropriate International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code. Providers must consider the appropriate DSM diagnosis for the client’s condition and determine the comparable covered ICD-9-CM diagnosis code.

Sufficient documentation must be maintained in the client’s medical record to support the diagnosis and justify the decision for placement into the program.

Services for caffeine or nicotine withdrawal are not benefits of Texas Medicaid.

CDTF services are limited to clients 20 years of age or younger. DSHS limits CDTF programs as follows:

- **Under the CDTF adolescent programs,** Texas Medicaid coverage for outpatient counseling services for substance abuse or dependence is limited to clients who are 13 through 17 years of age. However, young adults who are 18 through 20 years of age may receive services under the adolescent program when the screening process indicates the individual’s needs, experiences, and behavior are similar to those of adolescent clients.

- **Under the CDTF adult programs,** Texas Medicaid coverage for outpatient counseling services for substance abuse or dependence is limited to clients who are 18 through 20 years of age. However, adolescents who are 17 years of age may receive services under the adult programs when they are referred by the adult criminal justice system, or when the screening process indicates the individual’s needs, experiences, and behavior are similar to those of adult clients.

- Every exception to the general age requirements must be clinically justified and documented in writing by a QCC. The facility must maintain the supporting documentation, including the QCC admission approval, in the client’s medical record.

The following procedure code and modifier combinations must be used for CDTF outpatient counseling services provided by a QCC:

- H0004 with modifier HF (identifies individual counseling services provided in 15-minute increments)

- H0005 with modifier HF (identifies group counseling services provided in 1-hour increments)

  **Note:** Modifier HF identifies services in a substance abuse program.

CDTF outpatient group counseling for substance abuse or dependence is limited to 135 hours, per client, per calendar year (January 1 through December 31).
CDTF outpatient individual counseling for substance abuse or dependence is limited to 26 hours per client, per calendar year.

Outpatient group and individual counseling is only payable in the outpatient setting.

Clients in an inpatient status are not eligible for CDTF outpatient services.

CDTF outpatient counseling services do not include chemical dependency education, life skills training, assessments, or prevention services.

Clients in a residential chemical dependency treatment facility are not eligible for CDTF outpatient services.

CDTF outpatient counseling services must be submitted with one of the following diagnosis codes to be considered for reimbursement:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>29181 2919 2920 29289 2929 30300 30390 30400 30410 30420 30430</td>
</tr>
</tbody>
</table>

2.3.2 Prior Authorization
Prior authorization is not required for CDTF outpatient counseling services.

2.4 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including CDTF services. CDTF services are subject to retrospective review and recoupment if documentation does not support the service billed.

2.5 Claims Filing and Reimbursement

2.5.1 Claims Information
CDTF services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills or itemized statements are not accepted as claim supplements.

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

Section 6, Claims Filing (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Electronic billers must bill POS code 22 in the appropriate field and must submit their own provider identifier in the facility ID field. Providers should consult with their software vendor for the location of this field in the software.
2.5.2 Reimbursement

CDTFs are reimbursed in accordance with 1 TAC §355.8241. Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com. While CDTF services must be provided or supervised by a QCC such as a licensed chemical dependency counselor (LCDC), LCDCs are not reimbursed separately through Texas Medicaid.

Subsection 2.2, “Reimbursement Methodology” in Section 2, Texas Medicaid Reimbursement (Vol. 1, General Information) for more information.

3. MEDICAID CHILDREN’S SERVICES (CCP)

3.1 Early Childhood Intervention (ECI) (CCP)

ECI providers are eligible to enroll as CCP providers rendering service to clients birth through 35 months of age with a disability or developmental delay as defined by ECI criteria.

ECI CCP services end on the child’s third birthday.

To participate in Texas Medicaid, an ECI provider must comply with all applicable federal, state, and local laws and regulations about the services provided.

PT, OT, ST, and nutrition services are benefits for clients enrolled in ECI through CCP. CCP guidelines apply, including the requirement for evaluations.

The Texas ECI program is available statewide to families of children who are birth through 35 months of age and have disabilities or developmental delays. The state agency responsible for ECI services is the Department of Assistive and Rehabilitative Services (DARS). DARS contracts local ECI program providers who take referrals, determine eligibility for ECI, and provide services to eligible children.

ECI programs determine eligibility based on evaluations and assessments. Eligibility is determined by a team that includes ECI professionals and family members. The team works together to develop an Individualized Family Service Plan (IFSP) and case management plan to determine the appropriate services based on the unique needs of the child and child’s family. Children are eligible if they meet one or more of the following criteria:

- They have delays in one or more areas of development (cognitive, motor, communication, social-emotional or self-help skills)
- They have atypical development (children whose patterns of development are unusual or different from their peers)
- They have a medically diagnosed condition (children who have a condition, such as Down syndrome or spina bifida, that has a high probability of resulting in a developmental delay)

The ECI Developmental Rehabilitation Services (DRS) are reimbursed through the DARS ECI programs reimbursement process in accordance with 1 TAC §355.113 and DRS requirements in 40 TAC §108.501-§108.505.

ECI professionals are licensed or credentialed specialists, including early intervention specialists, speech and language pathologists, physical and occupational therapists, nurses, dieticians, social workers, counselors, and hearing and vision specialists.

Medicaid professionals can assist families by promptly scheduling appointments for well-child exams and providing documentation of the well-child exam and prescription (when necessary).

Other ECI services include physical, occupational, and speech therapy; nursing services; visions services; audiology services; developmental services; nutrition services; psychological services; social work; counseling; education and training; behavioral intervention; transportation; socialization services; health services; and assistive technology services and devices.
For more information on ECI services, providers may visit the EDI website at www.dars.state.tx.us/ecis/index.shtml.

Refer to: Subsection 3.10, “Therapy Services (CCP)” in this handbook for more information.

Subsection 3.6, “Medical Nutrition Counseling Services (CCP)” in this handbook for more information.

3.2 CCP Overview

CCP is an expansion of the EPSDT service as mandated by the OBRA of 1989, which requires all states to provide all medically necessary treatment for correction of physical or mental problems to THSteps-eligible clients when FFP is available, even if the services are not covered under the state’s Medicaid plan.

The following CCP provider sections describe the specific requirements of each area of responsibility:

- Subsection 3.3, “Clinician-Directed Care Coordination Services (CCP)” in this handbook.
- Subsection 3.4, “Comprehensive Outpatient Rehabilitation Facilities (CORFs)/ Outpatient Rehabilitation Facilities (ORFs)” in this handbook.
- Subsection 3.5, “Durable Medical Equipment (DME) Supplier (CCP)” in this handbook.
- Subsection 3.6, “Medical Nutrition Counseling Services (CCP)” in this handbook.
- Subsection 3.8, “Personal Care Services (PCS) (CCP)” in this handbook.
- Subsection 3.9, “Private Duty Nursing (CCP)” in this handbook.
- Subsection 3.10, “Therapy Services (CCP)” in this handbook for more information.
- Subsection 3.11, “Inpatient Psychiatric Hospital/Facility (Freestanding) (CCP)” in this handbook.
- Subsection 3.12, “Inpatient Rehabilitation Hospital (Freestanding) (CCP)” in this handbook.

3.2.1 Client Eligibility

The client must be from birth through 20 years of age and eligible for THSteps on the date of service. If the client’s Medicaid Identification (Form H3087) states “Emergency Care,” “PE,” or “QMB,” the client is not eligible for CCP benefits.

Clients are ineligible for CCP services beginning the day of their 21st birthday.

3.2.2 Enrollment

CCP providers must meet Medicaid/HHSC participation standards to enroll in the program. All CCP providers must be enrolled in Texas Medicaid to be reimbursed for services. Provider enrollment inquiries and application requests must be sent to the TMHP Provider Enrollment department at:

Provider Enrollment
Texas Medicaid & Healthcare Partnership
PO Box 200555
Austin, TX 78720-0555
Home and community support services agencies (HCSSAs) that want to provide CCP private-duty nursing (PDN), physical therapy (PT), speech therapy (ST), or occupational therapy (OT) services under the licensed-only home health (LHH) category must first enroll with TMHP. To enroll with TMHP in the LHH category, an HCSSA must:

- Complete a provider enrollment form, which can be found on the TMHP website at www.tmhp.com, provide its license information, and check the “Only CCP services” box on the form.
- Obtain a Texas Provider Identifier (TPI) for CCP services.
- Provide CCP PDN, PT, OT, or ST services only to eligible CCP clients and use the TPI number assigned for CCP services. Texas Medicaid fee-for-service services must be delivered under the licensed and certified home health (LCHH) category.

Refer to: Section 8, Managed Care (Vol. 1, General Information).

3.2.3 Services/Benefits and Limitations

Payment is considered for any health-care service that is medically necessary and for which FFP is available. CCP benefits are allowable services not currently covered under Texas Medicaid (e.g., speech-language pathology [SLP] services for nonacute conditions, PDN, prosthetics, orthotics, apnea monitors and some durable medical equipment [DME], some specific medical nutritional products, medical nutrition services, inpatient rehabilitation, travel strollers, and special needs car seats). CCP benefits also include expanded coverage of current Texas Medicaid services where services are subject to limitations (e.g., diagnosis restrictions for TPN or diagnosis restrictions for attendant care services).

Requests for services that require a prior authorization must be submitted to TMHP. Prior authorization is a condition for reimbursement, not a guarantee of payment. For information about specific benefits, providers can refer to provider-specific sections of this manual.

Payment cannot be made for any service, supply, or equipment for which FFP is not available. The following are some examples:

- Vehicle modification, mechanical, and/or structural (such as wheelchair lifts)
- Structural changes to homes, domiciles, or other living arrangements
- Environmental equipment, supplies, or services, such as room dehumidifiers, air conditioners, filters, space heaters, fans, water purification systems, vacuum cleaners, and treatments for dust mites, rodents, and insects
- Ancillary power sources and other types of standby equipment (except for technology-dependent clients such as those who are ventilator-dependent for more than 6 hours per day)
- Educational programs, supplies, or equipment (such as a personal computer or software)
- Equine or hippotherapy
- Exercise equipment, home spas or gyms, toys, therapeutic balls, or tricycles
- Tennis shoes
- Respite care (relief to caregivers)
- Aids for daily living (toothbrushes, spoons, reachers, and foot stools)
- Take-home drugs from hospitals (Eligible hospitals may enroll in and bill VDP. Pharmacies that want to enroll should call 1-512-491-1429)
- Therapy involving any breed of animal
3.2.4 Prior Authorization and Documentation Requirements

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. A prior authorization number (PAN) is a TMHP-assigned number establishing that a service or supply has been determined to be medically necessary and for which FFP is available. It is each provider’s responsibility to check the client’s Medicaid Identification (Form H3087) at the time each service is provided to verify eligibility. Any service provided while the client is not eligible cannot be reimbursed by TMHP. The responsibility for payment of services is determined by private arrangements made between the provider and client.

Prior authorization of CCP services may be requested in writing by completing the appropriate request form, attaching any necessary supportive documentation, and mailing or faxing it to the TMHP-CCP department. Prior authorization may also be requested through the TMHP website. (Providers can refer to subsection 5.3.1, “Prior Authorization Requests Through the TMHP Website” in Section 5, Prior Authorization (Vol. 1, General Information) for additional information to include, mandatory documentation, and retention requirements). All requested information on the form must be completed, or the request is returned to the provider. Incomplete forms are not accepted. If prior authorization is granted, the potential service provider (such as the DME supplier, pharmacy, RN, or physical therapist) receives a letter that includes the PAN, the procedures prior authorized, and the length of the authorization. Providers are notified in writing when additional information is needed to process the request for services.

Written requests for prior authorization are mandatory for the following services:

- The purchase of apnea monitors and the rental of apnea monitors for clients who are 5 months of age or older or after an initial 2 months of rental
- Diapers, wipes, and underpads for clients birth through 3 years of age
- Customized and noncustomized DME not authorized under Texas Medicaid (Title XIX) Home Health Services
- Formula for a client who is birth through 20 years of age if the client does not have a gastrostomy (G-tube)/jejunostomy or nasogastric tube or a metabolic disorder
- Inpatient freestanding psychiatric services
- Inpatient freestanding rehabilitation services
- Gastrostomy buttons (G-buttons) not authorized under Texas Medicaid (Title XIX) Home Health Services
- Non-face-to-face clinician-directed care coordination services
- Orthotics and prosthetics
- PDN
- PCS—Prior authorization requests for PCS services can only be submitted by DSHS. Providers can refer to subsection 3.8, “Personal Care Services (PCS) (CCP)” in this handbook for the authorization criteria.
- PT, OT, ST services
- TPN

Providers must submit a CCP Prior Authorization Request Form and documentation to support medical necessity to the CCP department before providing services. Providers must submit the CCP Prior Authorization Request Form when requesting a medically necessary service if the service is not addressed in the Texas Medicaid Provider Procedures Manual and the client is 20 years of age or younger.
**Important:** Documentation to support medical necessity of the service, equipment, or supply (such as a prescription, letter, or medical records) must be current, signed, and dated by a physician (MD or DO) before services are performed. Providers must keep the information on file.

**Refer to:** CCP provider-specific sections for prior authorization requirements of specific services.

### 3.2.4.1 Diagnosis Coding

All providers must obtain the client’s medical diagnosis from the physician. This information must be reflected on each claim submitted to TMHP using ICD-9-CM coding.

### 3.2.4.2 Drug and Medical Device Approval

Manufacturers may request to have drug or medical device products added as a CCP benefit by sending the information in writing to the following address:

HHSC  
1100 West 49th Street  
Austin, TX 78756-3179

HHSC reviews the information. Requests for consideration should not be sent to TMHP.

### 3.2.4.3 Physician Signature

The dated signature of the physician (MD or DO) on a prescription or CCP Authorization Request Form must be current to the service date(s) of the request, i.e., the signature must always be on or before the service start date and no older than 3 months before the current date(s) of service requested. Physician signatures dated after the service start date on initial requests cannot be accepted as documentation supporting medical necessity for dates of service prior to the signature date. A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. If services begin as a result of a verbal order before the physician’s dated signature, proof of the verbal order must be submitted with the request.

Stamped signatures and dates are not accepted on CCP Authorization Request Forms or prescriptions for CCP prior authorized services, supplies, or equipment. Verbal orders must be cosigned and dated by a physician (MD or DO) within 2 weeks, per provider policy. Signatures of NPs, clinical nurse specialist (CNSs), PAs, or doctors of philosophy (PhDs) are not accepted on CCP Authorization Request Forms or prescriptions for CCP prior authorized services.

Physician prescriptions must be specific to the type of service requested. For example, if the provider is requesting PT, the prescription must request physical therapy, not just therapy.

### 3.3 Clinician-Directed Care Coordination Services (CCP)

#### 3.3.1 Services/Benefits and Limitations

Clinician-directed (physician, APRN, and PA) care coordination services are a benefit of CCP for eligible clients who are birth through 20 years of age and have special health needs. These services are payable only to the clinician (primary care, specialist, or sub-specialist) who provides the medical home for the client.

To provide a medical home for the client, the primary care clinician directs care coordination together with the client and/or family. Care coordination consists of managing services and resources for clients with special health needs and their families to maximize the clients’ potential and provide them with optimal health care.
Clinician-directed care coordination services (face-to-face and non-face-to-face) must include the following components:

- A written care plan (either a formal document or documentation contained in the client’s progress notes) developed and revised by the medical home clinician, in partnership with the client, family, and other agreed-upon contributors. This plan is shared with other providers, agencies, and organizations involved with the care of the client, including educational and other community organizations with permission of the client and/or family. The care plan must be maintained by the medical home clinician and reviewed every 6 months or more frequently as necessary for the client’s needs.

- Care among multiple providers that are coordinated through the clinician.

- A central record or database maintained by the medical home clinician containing all pertinent medical information, including hospitalizations and specialty care.

- Assistance for the client and/or family in communicating clinical issues when a client is referred for a consultation or additional care, such as evaluation, interpretation, implementation, and management of the consultant recommendations for the client and/or family in partnership and collaboration with other providers, the client, and/or family.

Clinician-directed care coordination services should also include the supervision of the development and revision of the client’s emergency medical plan in partnership with the client, the family, and other providers for use by emergency medical services (EMS) personnel, utility service companies, schools, other community agencies, and caregivers.

Face-to-face care coordination services are encompassed within the various levels of E/M encounters and prolonged services.

Non-face-to-face clinician-directed care coordination services include:

- Prolonged services (procedure codes 99358 and 99359).

- Medical team conference (procedure code 99367).

- Care plan oversight/supervision, including telephone consultations with a specialist or subspecialist (procedure codes 99339, 99340, 99374, 99375, 99377, 99378, 99379, and 99380).

- Specialist or subspecialist telephone consultations (procedure code 99499 with modifier U9)

Non-face-to-face clinician-directed care coordination services are not considered case management by Texas Medicaid.

Specifically, non-face-to-face medical home clinician oversight/supervision of the development and/or revision of a client’s care plan may include the following activities, which do not have to be contiguous:

- Review of charts, reports, treatment plans, and lab or study results, except for the initial interpretation or review of lab or study results ordered during or associated with a face-to-face encounter.

- Telephone calls with other Medicaid-enrolled health-care professionals (not employed in the same practice) involved in the care of the client.

- Telephone or face-to-face discussions with a pharmacist about pharmacological therapies (not just ordering a prescription).

- Medical decision-making.

- Activities to coordinate services, if the coordination activities require the skill of a clinician.
• Documenting the services provided, which includes writing a note in the client’s chart describing the services provided, decision-making performed, and the amount of time spent performing the countable services, including the start and stop times and time spent by the physician working on the care plan after the nurse has conveyed pertinent information from agencies/facilities to the physician.

The following activities are not covered as non-face-to-face clinician supervision of the development and/or revision of the client’s care plan (care plan oversight services):

• Time that the staff spends getting or filing charts, calling home health agencies or clients, and similar administrative actions.

• Clinician telephone calls to client or family, except when necessary to discuss changes in client’s care plan.

• Clinician time spent telephoning prescriptions to a pharmacist (does not require clinician work and does not require a clinician to perform).

• Clinician time getting and/or filing the chart, dialing the telephone, or time on hold (does not require clinician work and does not meaningfully contribute to the treatment of the illness or injury).

• Travel time.

• Time spent preparing claims and for claims processing.

• Initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter.

• Services included as part of other E/M services.

• Consultations with health professionals not involved in the client’s case.

• Work included in hospital discharge day management (procedure codes 99238 and 99239) and discharge from observation (procedure code 99217).

3.3.1.1 Non-Face-to-Face Services

3.3.1.1.1 Non-Face-to-Face Medical Conferences

Procedure code 99367 must be used when billing for medical team conferences.

3.3.1.1.2 Non-Face-to-Face Clinician Supervision of a Home Health Client

Procedure codes 99374 or 99375 must be used when billing for services requiring interaction with a home health agency.

3.3.1.1.3 Non-Face-to-Face Clinician Supervision of a Hospice Client

Procedure codes 99377 or 99378 must be used when billing for services requiring interaction with a hospice.

3.3.1.1.4 Non-Face-to-Face Clinician Supervision of a Nursing Facility Client

Procedure codes 99379 or 99380 must be used when billing for services requiring interaction with a nursing facility.

3.3.1.1.5 Other Non-Face-to-Face Supervision

Procedure codes 99339 or 99340 must be used when billing for services requiring interaction with an independently-enrolled nurse or other provider (e.g., not a home health agency, nursing facility, or hospice provider).
3.3.1.1.6 Non-Face-to-Face Prolonged Services

Procedure codes 99358 or 99359 must be used when billing for prolonged services without face-to-face contact. This service is to be reported in addition to other clinician services, including E/M services at any level, or health-care professionals outside of an home health agency, hospice, or nursing facility.

Non-face-to-face prolonged services are limited to a maximum of 90 minutes once per client by the same provider unless one of the following significant changes in the client’s clinical condition occurs:

- The client will soon be, or has recently been, discharged from a prolonged and complicated hospitalization that required coordination of complex care with multiple providers in order for the client to be adequately cared for in the home.
- The client has experienced recent trauma resulting in new medical complications that require complex interdisciplinary care.
- The client has a new diagnosis of a medically complex condition requiring additional interdisciplinary care with additional specialists.

Procedure code 99359 must be billed on the same date of service as procedure code 99358. Additional prolonged non-face-to-face services may be authorized if the provider submits supporting documentation for authorization.

Procedure code 99358 must be used to report the first hour of prolonged services and must be billed with the appropriate physician evaluation and management (E/M) procedure code listed in the table below. Prolonged services of less than 30 minutes are considered part of the first hour.

### Procedure Codes

<table>
<thead>
<tr>
<th>99201</th>
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Procedure code 99359 is used to report an additional 15 to 30 minutes of prolonged non-face-to-face services beyond the first hour. Prolonged services of less than 15 minutes beyond the first hour are considered part of the first hour.

3.3.1.1.7 Non-Face-to-Face Specialist or Subspecialist Telephone Consultation

Telephone consultations are limited to two every six months to the same provider and will not be reimbursed to the clinician providing the medical home.

The clinician providing the medical home must have an authorization on file for one of the following procedure codes before the specialist or subspecialist can be reimbursed:

### Procedure Codes

<table>
<thead>
<tr>
<th>99339</th>
<th>99340</th>
<th>99358</th>
<th>99374</th>
<th>99375</th>
<th>99377</th>
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</table>

Because the specialist or sub-specialists cannot be reimbursed without the medical home clinician’s current prior authorization information, the clinician providing the medical home should provide their information to the specialist or subspecialist.
The specialist or subspecialist will not be separately reimbursed for the telephone consultation if he or she is the medical home clinician because care plan oversight by the medical home provider includes telephone consultations. The referring provider identifier and prior authorization number must be submitted on the claim.

3.3.1.1.8 General Requirements for Non-Face-to-Face Clinician-Directed Care Coordination Services

These services may be reimbursed for the medical home clinician time involved in this coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to or performed by others do not count towards care coordination reimbursement. Care coordination provided during post-surgical care is a benefit if the care is unrelated to the surgery.

3.3.1.1.9 Non-Face-to-Face Care Plan Oversight

The medical home clinician who bills for the care plan oversight must be the clinician who signed the POC in the home or domiciliary (procedure codes 99339 and 99340), home health agency (procedure codes 99374 and 99375), hospice (procedure codes 99377 and 99378), or nursing facility (procedure codes 99379 and 99380).

Procedure code 99339 is denied when billed on the same date of service by the same provider as procedure code 99340.

Procedure code 99374 is denied when billed on the same date of service by the same provider as procedure code 99375.

Procedure code 99377 is denied when billed on the same date of service by the same provider as procedure code 99378.

Procedure code 99379 is denied when billed on the same date of service by the same provider as procedure code 99380.

Care plan oversight services may be reimbursed for the clinician time involved in this coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to or performed by others do not count towards care coordination reimbursement.

Only 2 clinician-directed care plan oversight services (procedure codes 99339 or 99340, 99374 or 99375, 99377 or 99378, and 99379 or 99380) are reimbursed every 6 months.

Payment is made only to one clinician per client per calendar month for procedure code 99374 or 99375.

The medical home clinician may not have a significant financial or contractual relationship with the home health agency as defined in 42 CFR §424.

The medical home clinician may not be the medical director or employee of the hospice and may not furnish services under arrangements with the hospice, including volunteering.

3.3.1.1.10 Medical Team Conference

One medical team conference (procedure code 99367) may be reimbursed once every 6 months when the medical home coordinating clinician attests that they are providing the medical home for the client. The coordinating clinician may be the client’s primary care provider or a specialist.

Additional medical team conferences may be considered with documentation of a change in the client’s medical home.

The medical team conference time must be documented in the client’s record.
3.3.1.2 **Face-to-Face Services**

### 3.3.1.2.1 General Requirements for Face-to-Face Clinician-Directed Care Coordination Services

Providers must use the most appropriate face-to-face E/M procedure codes to bill for care coordination services.

- When counseling or care coordination requires more than 50 percent of the client and/or family encounter (face-to-face time in the office or other outpatient setting, or floor/unit time in the hospital), then time may be considered the key or controlling factor to qualifying for a particular level of E/M service.

- Counseling is a discussion with the client and/or family concerning diagnostic studies or results, prognosis, risks and benefits, management options, importance of adhering to the treatment regimen, and client and family education.

Modifiers must be used as appropriate for billing.

Any face-to-face inpatient or outpatient E/M procedure code that is a benefit of Texas Medicaid, except hospital discharge-day management (procedure codes 99238 and 99239) and discharge from observation (procedure code 99217), may be billed on the same day as the following non-face-to-face clinician-directed care coordination procedure codes when the procedure requires significant, separately-identifiable E/M services by the same physician on the same day.

### 3.3.2 Prior Authorization and Documentation Requirements

Non-face-to-face clinician-directed care coordination services provided by the medical home require prior authorization. Providers must submit a request for prior authorization within 7 business days of the date of service. Prior authorization is limited to a maximum of 6 months. Prior authorization is required to recertify the client for additional 6-month periods and requires submission of a new request with documentation supporting medical necessity for ongoing services.

Prior authorization for initial non-face-to-face clinician-directed care coordination requires documentation of at least one covered face-to-face inpatient or outpatient E/M visit by the medical home clinician directing the care coordination during the 6 months preceding the provision of the first non-face-to-face care coordination service.

Prior authorization for subsequent non-face-to-face clinician-directed care coordination services requires at least one covered face-to-face inpatient or outpatient E/M visit by the medical home clinician directing the care coordination during the previous 12 months or more frequently as indicated by the client’s condition.

Prior authorization of CCP services may be requested in writing by completing a CCP Prior Authorization Request Form, attaching the necessary supportive documentation as detailed below, and mailing or faxing it to the TMHP-CCP department:

Texas Medicaid & Healthcare Partnership  
Comprehensive Care Program  
PO Box 200735  
Austin, TX 78720-0735  
Fax: 1-512-514-4212
For prior authorization to be considered, clients must require complex and multidisciplinary care modalities involving regular clinician development and/or revision of care plans, review of subsequent reports of client status, and review of related laboratory and other studies.

- **Medically complex**: The health care needed by a Medicaid client achieves the designation of medically complex when the approved plan of care (POC) necessitates a clinical professional practicing within the scope of his or her license and in the context of a medical home to coordinate ongoing treatment to ensure its safe and effective delivery. The diagnosis must be covered under Texas Medicaid and be characterized by one of the following:
  - Significant and interrelated disease processes that involve more than one organ system (including behavioral health diagnoses) and require the services of two or more licensed clinical professionals, specialists, or subspecialists.
  - Significant physical or functional limitations that require the services of two or more therapeutic or ancillary disciplines, including, but not limited to, nursing, nutrition, OT, PT, ST, orthotics, and prosthetics.
  - Significant physical, developmental, or behavioral impairment that requires the integration of two or more medical and/or community-based providers, including, but not limited to, educational, social, and developmental professionals, that impact the care of the client.

- **Multidisciplinary Care**: Care is multidisciplinary when the medically necessary covered services of an approved POC include the need to coordinate the assessment, treatment, and/or services of a Medicaid-enrolled clinical provider with two or more additional medical, educational, social, developmental, or other professionals impacting the health care of the client.

Prior authorization is effective for care coordination services provided over a period of 6 months. Medical home clinicians must submit a revised care plan for subsequent periods of prior authorization.

Documentation of the following components must be submitted with the prior authorization form to obtain an initial authorization or renewal:

- A current medical summary, encompassing all disciplines and all aspects of the client’s care, and containing key information about the client’s health, including conditions, complexity, medications, allergies, past surgical procedures, etc.
- A current list of the main concerns/issues/problems as well as key strengths/assets and the related current clinical information including a list of all diagnoses with ICD-9-CM diagnosis codes.
- Planned action steps/interventions to address the concerns and to sustain/build strengths, with the expected outcomes.
- Disciplines involved with the client’s care and how the multiple disciplines will work/are working together to meet the client’s need. Providers should explain how the multidisciplinary approach will/do benefit the client’s needs.
- Short-term and long-term goals with timeframes.

The supporting documentation can be any of the following:

- A formal written care plan
- Progress note detailing the care coordination planning
- A letter of medical necessity detailing the care plan oversight and care coordination

Clinician-directed care coordination services must be documented in the client’s medical record. Documentation must support the services being billed and must include a record of the medical home clinician’s time spent performing specific care coordination activities, including start and stop times.
The documentation should also include a formal care plan and an emergency services plan. The supporting documentation maintained in the client’s medical records must be dated and include the following components and requirements:

- Problem list
- Interventions
- Short-term and long-term goals
- Responsible parties

Client medical records are subject to retrospective review.

Documentation for care coordination provided during post-surgical care must clearly indicate the care coordination is unrelated to the surgery.

3.3.2.1 Documentation Requirements for the Medical Home Clinician for a Telephone Consult with a Specialist

The clinician providing the medical home must maintain the following documentation in the client’s medical record:

- Start and stop times showing that the consultation was at least 15 minutes long
- The reason for the call
- The specialist’s or subspecialist’s medical opinion
- The recommended treatment and/or laboratory services
- The name of the specialist or subspecialist

3.3.2.2 Documentation Requirements for the Specialist or Subspecialist for a Telephone Consult with the Medical Home Clinician

Specialists or subspecialists must complete and retain the Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician Directed Care Coordination Services-CCP. These records are subject to retrospective review. The supporting documentation must include, but not limited to the following:

- The client’s name, date of birth, and Medicaid identification number
- Start and stop times indicating the consultation lasted at least 15 minutes
- The reason for the call
- The specialist’s or subspecialist’s medical opinion
- The recommended treatment and/or laboratory services
- The name and phone number of the clinician providing the medical home
- Provider information for the specialist’s or subspecialist’s and the clinician providing the medical home

3.3.3 Claims Information

Claims for clinician-care coordination services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 claims form. Providers may purchase CMS-1500 claims from the vendor of their choice. TMHP does not supply the forms.
Refer to: Section 3, TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6, Claims Filing (Vol. 1, General Information) for general information about claims filing.


3.3.4 Reimbursement
Clinician-directed care coordination services are reimbursed in accordance with 1 TAC §355.8441.

3.4 Comprehensive Outpatient Rehabilitation Facilities (CORFs)/Outpatient Rehabilitation Facilities (ORFs)

3.4.1 Enrollment
CORFs/ORFs providers must be certified by Medicare, have a valid provider agreement with HHSC, and have documentation that the TMHP enrollment process has been completed.

For questions about enrollment or billing, call the TMHP Contact Center at 1-800-925-9126.

Refer to: Subsection 1.1, “Provider Enrollment” in Section 1, Provider Enrollment and Responsibilities (Vol. 1, General Information) for information about enrollment procedures.

3.4.2 Services/Benefits and Limitations
CORFs and ORFs can bill only outpatient rehabilitation services to Texas Medicaid for CCP clients and all CORF and ORF services require prior authorization.

Medicaid clients who are birth through 20 years of age are entitled to all medically necessary services under the following conditions:

- The requested services correct or ameliorate the client’s disability, physical or mental illness, or condition.
- No TPR is financially responsible for the services.
- The documentation must support medical necessity clearly and consistently and must describe the client’s current diagnosis, functional status, and condition.

Providers must consistently describe the treatment throughout the documentation and provide a sufficient explanation as to how the requested services correct or ameliorate the client’s disability or physical or mental illness or condition.

The client must be eligible for CCP and under a physician’s treatment for consideration of reimbursement.

Clients receiving therapy services reimbursed by CCP must have conditions that require ongoing medical supervision. To establish medical necessity, a physician’s prescription and a revised therapy treatment plan are required at least once every 6 months. Therapy services for acute conditions are reimbursed by Texas Medicaid.

PT, OT, and ST services require prior authorization. Providers must use modifier GN (ST), GO (OT), or GP (PT) to identify the type of therapy being requested. Providers must file claims with these modifiers to identify the type of therapy performed. Claims received without the appropriate modifiers are denied with the explanation of benefit (EOB), “This procedure requires a modifier. Please appeal claim with the appropriate modifier.”

PT, OT, and ST evaluations should be billed using appropriate procedure codes. These codes should be billed with a quantity of 1 for each type of therapy performed (PT, OT, or ST), regardless of the time spent with the client.
PT, OT, and ST encounters should be billed in increments of 15 minutes (i.e., a quantity of 1 equals 15 minutes; a quantity of 2 equals 30 minutes, etc.).

Refer to: Subsection 3.10, “Therapy Services (CCP)” for information about billing 15-minute increments.

Providers can only bill for time spent with the client present, including assisting the client with learning to use adaptive equipment and assistive technology. The evaluation and reevaluation procedure codes are inclusive payments that include the written report and other administrative tasks. Time spent without the client present, such as report writing and training aides to work with the client (unless the client is present during training), is not billable.

Evaluations and reevaluations are reimbursed as a per-evaluation or reevaluation encounter with a quantity of 1. An evaluation and therapy of the same discipline/type are not reimbursable when they are performed on the same date of service, e.g., PT evaluation and PT encounters are not payable for the same date of service. OT, PT, and ST evaluations can be reimbursed once per 6 months to any provider. OT, PT, and ST reevaluations can be reimbursed once per month to any provider. An evaluation or reevaluation performed on a more frequent basis would be outside the current benefit limitations and would only be considered for reimbursement with prior authorization or written documentation of medical necessity. CORFs and ORFs are subject to a maximum of 8 units (2 hours) each of PT, OT, or ST services per date of service, per client.

The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

The procedures below may be payable to CORFs/ORFs based on a PPS fee schedule.

<table>
<thead>
<tr>
<th>Code</th>
<th>Type</th>
<th>Modifier</th>
<th>Billing Increment</th>
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<tbody>
<tr>
<td>97012</td>
<td>PT, OT</td>
<td>GO, GP</td>
<td>Per 15 min.</td>
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<tr>
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<td>PT, OT</td>
<td>GO, GP</td>
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<td>PT, OT</td>
<td>GO, GP</td>
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<tr>
<td>97034</td>
<td>PT, OT</td>
<td>GO, GP</td>
<td>Per 15 min.</td>
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3.4.3 Prior Authorization and Documentation Requirements

A request for prior authorization must include documentation from the provider that supports the medical necessity of the service.

The initial therapy request must include the following:

- A Request for Initial Outpatient Therapy (Form TP-1) that has been signed and dated by the therapist and physician.
- A copy of the current evaluation that has been signed and dated by the therapist.
- Documentation that indicates the treatment goals.
- Documentation that indicates the anticipated measurable progress toward goals.
- Documentation that explains the client’s gross or fine motor delays or expressive or receptive delays in years or months compared to chronological age.

The extension of the therapy request must include the following:

- A Request for Extension of Outpatient Therapy (Form TP-2) signed and dated by the therapist and physician.
- A summary statement of measurable progress made during the treatment period.
- Documentation indicating new treatment goals.
- Documentation indicating anticipated measurable progress for the next treatment period.

All physician and provider signatures on the TP-1 and TP-2 forms, physician orders, and other documentation must be current, unaltered, original, handwritten, and dated. Computerized or stamped signatures and dates are not accepted.
Refer to: Form CH.12, “Request for Initial Outpatient Therapy (Form TP-1)” in Section 8, “Forms,” of this handbook.

Form CH.13, “Request for Extension of Outpatient Therapy (Form TP-2) (2 Pages)” in Section 8, “Forms,” of this handbook.

If a provider discontinues therapy with a client and a new provider begins therapy during an existing authorization period, a new evaluation must be submitted. Prior authorization is mandatory and is not a guarantee of payment. Providers must adhere to filing guidelines for payment consideration.

3.4.4 Claims Information

Providers must submit services provided by CORFs/ORFs in an approved electronic claims format or on the UB-04 CMS-1450 claims form. Providers may purchase these claim forms from the vendor of their choice. TMHP does not supply the forms. Submit electronic claims with a PAN. Failure to provide a PAN on an electronic claim results in claim denial.

Refer to: Subsection 3.4, “Comprehensive Outpatient Rehabilitation Facilities (CORFs)/Outpatient Rehabilitation Facilities (ORFs)” in this handbook for more information about PANs.

The procedure codes that CORFs/ORFs use are UB-04 CMS-1450 revenue or CPT codes. The only POS is outpatient facility (POS 5).

The PAN must be identified in Block 63 of the UB-04 CMS-1450 claim form or the appropriate field of the electronic software. PT, OT, and ST evaluations should be billed with procedure code B-424, B-434, or B-444. This code should be billed with a quantity of 1 for each type of therapy performed (PT, OT, and ST), regardless of time spent with the client. The codes used for billing therapy are the CPT codes. The codes are in the 90000 series. The Texas Medicaid Bulletin provides updates to the CPT codes.

Refer to: Form CH.22, “Comprehensive Outpatient Rehabilitation Facility (CORF) (CCP Only)” in this handbook for a claim form example.

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

Section 6, Claims Filing (Vol. 1, General Information) for general information about claims filing.


3.4.5 Reimbursement

CORFs and ORFs are reimbursed in accordance with 1 TAC 355.8441. See the applicable fee schedule on the TMHP website at www.tmhp.com.

3.5 Durable Medical Equipment (DME) Supplier (CCP)

3.5.1 Enrollment

To be eligible to participate in CCP, providers of DME (including customized or non-basic medical equipment) and expendable medical supplies must be enrolled in Medicare.

Home health agencies that provide DME and supplies should refer to Subsection 1.1, “Enrollment ” in Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) to enroll as DME–Home Health Services (DMEH) providers.

3.5.1.1 Pharmacies (CCP)

Pharmacy providers are eligible to participate in CCP. To be enrolled in CCP, the pharmacy must also be enrolled in the Vendor Drug Program (VDP).
This enrollment allows pharmacy providers to bill for those medications and supplies payable by Medicaid for clients who are birth through 20 years of age but not covered by VDP (e.g., some over-the-counter drugs, some nutritional products, diapers, and disposable or expendable medical supplies). Pharmacy providers must continue to bill HHSC for drugs covered under VDP.

Refer to: Subsection 3.2.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.


Section 1, “Texas Medicaid (Title XIX) Home Health Services” in Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) for details about coverage through Texas Medicaid (Title XIX) Home Health Services.

3.5.2 Services/Benefits and Limitations

Medicaid clients who are birth through 20 years of age are entitled to all medically necessary DME and expendable medical supplies. DME or supplies are medically necessary when required to correct or ameliorate disabilities or physical or mental illnesses or conditions. Any numerical limit on the amount of a particular item of DME or expendable medical supply can be exceeded if medically necessary for Medicaid clients who are birth through 20 years of age. Likewise, time periods for replacement of DME and expendable medical supplies do not apply to Medicaid clients who are birth through 20 years of age if the replacement is medically necessary.

DME is defined as medical equipment that is manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate the client’s disability, condition, or illness.

Because there is no single authority (such as a federal agency) that confers the official status of “DME” on any device or product, HHSC retains the right to make such determinations with regard to DME covered by Texas Medicaid. DME covered by Texas Medicaid must either have a well-established history of efficacy or, in the case of novel or unique equipment, valid peer-reviewed evidence that the equipment corrects or ameliorates a covered medical condition or functional disability.

Requested DME may be a benefit of Texas Medicaid when it meets the Medicaid definition of DME.

The majority of DME and expendable medical supplies are covered through Texas Medicaid (Title XIX) Home Health Services.

If a service cannot be provided through Texas Medicaid (Title XIX) Home Health Services, the service may be covered through CCP if it is determined to be medically necessary for the client and if FFP is available.

If a DME provider is unable to deliver a piece of equipment, the provider should allow the client the option of obtaining the DME or expendable medical supplies from another provider.

Periodic rental payments are made only for the lesser of the following:

- The period of time the equipment is medically necessary
- The total monthly rental payments equal the reasonable purchase cost for the DME

DME will be purchased when a purchase is determined to be medically necessary and more cost effective than leasing the device with supplies. Only new, unused equipment will be purchased. When a provider is replacing a piece of rental DME with purchased DME, the provider must supply a new piece of DME to the client.

Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.
DME repair will be considered based on the age of the item and cost to repair it. A request for repair of DME must include:

- A statement or medical information that is provided by the attending physician and that substantiates the medical appliance or equipment continues to serve a specific medical purpose.
- An itemized estimated cost list from the vendor or DME provider who will make the repairs.

Rental equipment may be provided to replace purchased medical equipment for the period of time it will take to make necessary repairs to purchased medical equipment.

All adjustments and modifications that are made within the first 6 months after delivery are considered part of the purchase price. However, DME that has been delivered to the client’s home and then found to be inappropriate for the client’s condition will not be eligible for an upgrade within the first 6 months following purchase unless there had been a significant change in the client’s condition, as documented by the physician familiar with the client.

Rental reimbursement to the same provider cannot exceed the purchase price, except as addressed in specific policies.

All DME purchased for a client becomes the Medicaid client’s property upon receipt of the item. Delivered equipment will become the Medicaid client’s property in the following instances even though it will not be prior authorized or reimbursed:

- Equipment delivered to the client before the physician signature date on the CCP Prior Authorization Form or prescription.
- Equipment delivered more than 3 business days before obtaining prior authorization from TMHP that meets the criteria for purchase.

As long as the client is eligible for CCP services on the date the custom equipment is ordered from the manufacturer, the provider should use the order date as the date of service since custom equipment is client specific and cannot be used for another client.

To establish medical necessity of the equipment for the client, the provider must have on file in the client’s records current documentation that is signed by a physician (e.g., signed and dated prescription) showing the following:

- A diagnosis relative to each item requested
- The specific type of supply needed
- The length of time needed

### 3.5.2.1 Purchase Versus Equipment Rental

When providing equipment not prior authorized under Texas Medicaid (Title XIX) Home Health Services for CCP clients with long-term or chronic conditions, it is more cost-effective, in many cases, to purchase the equipment rather than rent it. The client’s condition and length of time the equipment will be used should be carefully assessed before prior authorization for rental or purchase is requested. CCP nurses determine whether the equipment will be rented, purchased, repaired, or modified based on the client’s needs, the duration of use, and the age of the equipment.

CCP does not pay for the purchase of certain types of equipment; consequently, long-term rental may be considered. Most other equipment is rented for only 4 months initially. During this time, the provider should assess whether the equipment should be purchased before the rental lapses. Rentals and purchases must be prior authorized.

After prior authorization is obtained for purchase, new equipment must be provided and the rental discontinued. CCP does not purchase used equipment.
Providers of customized or nonbasic medical equipment also must be enrolled as Medicare DME providers.

### 3.5.3 Prior Authorization and Documentation Requirements

Providers can request prior authorization for most DME through the TMHP website. Providers that make written requests for prior authorization must complete Form CH.1, “CCP Prior Authorization Request Form” in this handbook, and they must attach the documentation necessary to support the request. The documentation must include a current prescription that has been signed and dated by a physician (MD or DO), and it must be mailed or faxed to TMHP with the prior authorization request. For specific policy information not contained in this manual related to the purchase of DME, providers can call TMHP-CCP Customer Service at 1-800-846-7470.

A completed CCP Prior Authorization Request Form prescribing the DME and/or medical supplies must be signed and dated by the prescribing physician familiar with the client before requesting prior authorization. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates are not accepted. The completed CCP Prior Authorization Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician’s medical record for the client.

To avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of the medical necessity for the equipment/services requested. The physician must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for the mobility aid.

A determination is made by the CCP nurses as to whether the equipment will be rented, purchased, repaired, or modified based on the client’s needs, duration of use, and age of equipment.

A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or expendable medical supply. Physician prescriptions must be specific to the item requested. For example, if the provider is requesting a customized wheelchair, the prescription must request a customized wheelchair, not just a wheelchair.

#### 3.5.3.1 Equipment Accessories

CCP may consider prior authorization of equipment accessories, such as ventilator and oxygen trays and positioning inserts, when supporting documentation takes into account all the client’s needs, capabilities, and physical/mental status.

#### 3.5.3.2 Equipment Modifications

A modification is the replacement of a component due to changes in the client’s condition, not the replacement of a component that is no longer functioning.

DME that has been delivered to the client’s home and then found to be inappropriate for the client’s condition will not be eligible for an upgrade within the first 6 months following purchase. All modifications that are made within the first 6 months after delivery are considered part of the purchase price.

However, CCP may consider prior authorization of modifications to custom equipment if a change occurs in the client’s needs, capabilities, or physical/mental status that cannot be anticipated. Documentation must include:

- All projected changes in the client’s needs.
- The age of the current equipment, and the cost of purchasing new equipment versus modifying current equipment.

#### 3.5.3.3 Equipment Adjustments

Adjustments do not require supplies.
Labor for adjustments within the first 6 months after delivery are not prior authorized because these are considered part of the purchase price.

Up to 1 hour of labor for adjustments may be considered for reimbursement with prior authorization through CCP as needed after the first 6 months. Providers must use procedure code K0739 for adjustments.

3.5.3.4 Equipment Repairs

Repairs require replacement of components that are no longer functional. Repairs to client-owned equipment may be considered for reimbursement with prior authorization through CCP.

Technician fees are considered part of the cost of the repair. Providers must use procedure code K0739.

Repairs for non-warranty DME may be billed using procedure code K0739. Non-warranty DME repairs will require prior authorization. Providers are responsible for maintaining documentation in the client’s medical record that specifies the repairs and supporting medical necessity.

Rentals may be considered for reimbursement during the repair period of the client’s owned equipment.

Routine maintenance of rental equipment is the provider’s responsibility.

3.5.3.5 DME Certification and Receipt Form

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. Providers must retain individual delivery slips or invoices for each date of service to document the date of delivery for all supplies provided to a client. Providers must disclose this documentation to the Health and Human Services Commission (HHSC) or its designee upon request. Documentation of delivery must include one of the following:

- Delivery slip or invoice signed and dated by client/caregiver. The delivery slip or invoice must contain the client’s full name and address to which the supplies were delivered, the item description, and the numerical quantities that were delivered to the client.

- A dated carrier tracking document with shipping date and delivery date. The dated carrier tracking document must be attached to the delivery slip or invoice. The dated delivery slip or invoice must include an itemized list of goods, which includes the descriptions and numerical quantities of the supplies delivered to the client. This document can include other information, such as prices, shipping weights, shipping charges, and any other description.

DME claims and appeals that meet or exceed a billed amount of $2,500 for the same date of service will suspend for verification of client receipt of the DME item(s). The DME Certification and Receipt Form must be faxed to 1-512-506-6615. If the claim is submitted without the form or if receipt of the DME item(s) cannot be verified, the DME item(s) on the claim will be denied. TMHP may contact the client that received the product for verification of services rendered.

3.5.3.6 Specific CCP Policies

Most DME and expendable medical supplies are available under Texas Medicaid (Title XIX) Home Health Services. If the service is not available under Texas Medicaid (Title XIX) Home Health Services, CCP may cover the requested service, if the client is CCP-eligible and the service is medically necessary, requested by a physician, and for which FFP is available.
Refer to: Form DM.1, “DME Certification and Receipt Form (3 pages)” in Section 6, Forms, in Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks).

Section 1, “Texas Medicaid (Title XIX) Home Health Services” in Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) for specific policies.

3.5.4 Cardiorespiratory (Apnea) Monitor

3.5.4.1 Services/Benefits and Limitations

Apnea monitors are a benefit of CCP for infants. The purchase of an apnea monitor (procedure code E0618 or E0619) is limited to once every 5 years. The rental of an apnea monitor (procedure code E0619) is limited to once per month.

The rental of an apnea monitor with recording feature may be considered for 2 months without prior authorization for infants up to 4 months of age with one of the following diagnosis codes.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>33700</td>
</tr>
<tr>
<td>53081</td>
</tr>
<tr>
<td>7850</td>
</tr>
</tbody>
</table>

Diagnosis code 42789 includes atrial tachycardia (SVT, AV nodal reentry, nodal, and sinoauricular) and bradycardia (nodal, sinoatrial).

Other diagnoses may be considered for prior authorization based on medical necessity. Use of diagnosis code V198 may be considered on appeal, and requires submission of additional documentation to support medical necessity.

Procedure code 94774 may be used by the physician to bill for the interpretation of the apnea monitor recordings.

Electrodes and lead wires (procedure codes A4556 and A4557) for the apnea monitor are a benefit only if the apnea monitor is owned by the client. Additional documentation such as the purchase date, the serial number, and purchasing entity may be requested. Procedure code A4556 may be considered for purchase for a maximum of 15 pairs per month. Procedure code A4557 may be considered for purchase for a maximum of 2 pairs per month. Additional lead wires may be requested on appeal with documentation of medical necessity. The physician must provide medical necessity for the electrodes, lead wires, and a statement that the client owns the monitor. If the apnea monitor is rented, the electrodes and lead wires are considered part of the rental fee.

The apnea monitor/pulse oximeter combination device is not a benefit of Texas Medicaid.

3.5.4.2 Prior Authorization and Documentation Requirements

Prior authorization for the purchase of an apnea monitor with or without recording features may be considered for use in the home with one of the diagnosis codes listed in the table below.

Prior authorization is required for rental of an apnea monitor, if one of the following conditions exist:

- The client is 5 months of age or older.
- A documented cardiorespiratory episode occurred during the initial 2-month rental period requiring continued monitoring.

Clients who are 5 months of age or older must have demonstrated an apparent life-threatening event, tracheostomy, anatomic abnormality of the airway, chronic lung disease requiring oxygen or ventilatory support, or other diagnoses based on documented medical necessity.
Prior authorization must be obtained in writing and must include all of the following:

- A completed CCP Prior Authorization Request Form signed and dated by the physician
- Documentation to support medical necessity and appropriateness of the apnea monitor
- A physician interpretation, signed and dated by the physician, of the most recent 2 months’ apnea monitor downloads if the client has used an apnea monitor

Apnea monitors are not prior authorized if the documentation does not support medical necessity.

### 3.5.5 Croup Tent/Pulse Oximeter

#### 3.5.5.1 Services/Benefits and Limitations

##### 3.5.5.1.1 Croup Tent

The croup tent consists of a plastic tent and humidification system placed over a crib or bed to provide a high humidity environment.

The rental of a croup tent (procedure code E1399) is a benefit of Texas Medicaid through CCP. Rental of the croup tent includes purchase of the croup tent canopy, rental of a compressor, setup charge, and supplies.

Separate payment is not made for individual components.

##### 3.5.5.1.2 Pulse Oximeter

A pulse oximeter (procedure code E0445) is a benefit of Texas Medicaid through CCP. A higher-level pulse oximeter (procedure code E0445 with modifier TF or TG) may be reimbursed based on documentation of medical necessity. Modifier TF or TG must be submitted in addition to procedure code E0445 depending on the level of care. Modifier TF is used for intermediate level of care, and modifier TG for complex/high level of care.

A pulse oximeter rental is limited to once per month for a maximum of 6 months. For those clients who require long-term monitoring, recertification may be considered for up to a maximum of 6 additional months. Purchase may be considered when it is determined to be medically necessary and more cost-effective than leasing the device with supplies. Before purchase, the provider must supply a new pulse oximeter to the client.

Pulse oximeters may be purchased when a purchase is determined to be medically necessary and more cost-effective than leasing the device with supplies. Prior to purchase, the provider must supply a new pulse oximeter to the client. A pulse oximeter may be reimbursed for purchase once every 5 years.

The provider is responsible for retaining a current prescription.

The rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts. Pulse oximeter sensor probes (procedure code A4606) for client-owned equipment are limited to 4 per month without prior authorization.

#### 3.5.5.2 Prior Authorization and Documentation Requirements

##### 3.5.5.2.1 Croup Tent

A croup tent requires prior authorization. A completed CCP prior authorization form and documentation to support medical necessity must be submitted to CCP prior authorization unit.

Reimbursement for the croup tent is limited to monthly rental, regardless of whether the therapy is medically necessary for only one day or one week.

##### 3.5.5.2.2 Pulse Oximeter

A pulse oximeter requires prior authorization.
A pulse oximeter may be considered for prior authorization for clients who are birth through 20 years of age who meet the following criteria for the level requested:

- **Level One.** Basic level monitoring capable of spot checks and heart rate. Applicable if there is a caregiver and/or medical provider identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way and the client meets at least one of the following criteria:
  - Client is oxygen- and/or ventilator-dependent (Less than 8 hours per day).
  - Client is clinically stable and able to wean from oxygen and/or ventilator.
  - Client has other medically necessary condition(s) requiring monitoring of oxygen saturation.

- **Level Two.** Providers must use modifier TF when the oximeter device is for intermediate level of care and continuous monitoring, alarm, memory, and correction of motion artifact. Applicable if the client meets all the following criteria:
  - Client is oxygen- and/or ventilator-dependent a significant portion of the day (e.g., 8 to 16 hours per day).
  - Client needs continuous monitoring of oxygen saturation during sleep and/or to maintain optimal levels.
  - There is a caregiver and/or medical provider identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way.

- **Level Three.** Providers must use modifier TG if the oximeter device is for a serious condition and there is critical need for continuous monitoring. Applicable if the client meets all the following criteria:
  - Client has frequent need for changes in oxygen and ventilator settings.
  - Client is oxygen- and/or ventilator-dependent (e.g., 16 to 24 hours per day).
  - Client is in the weaning process from oxygen and/or ventilator and experiencing respiratory complications.
  - Client requires equipment that is motion-sensitive or that has more complex readouts or monitoring capabilities.
  - There is a caregiver and/or medical provider identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way.

For all requests providers must:

- Submit the completed Form CH.11, “Pulse Oximeter Form” and Form CH.1, “CCP Prior Authorization Request Form” in this handbook.
- Clearly indicate medical necessity using the TF and TG modifiers on the Pulse Oximeter Form.
- Continue to use the current code for lease (E0445 with modifier RR) and purchase (E0445 with modifier NU).

A pulse oximeter rental includes the system, the sensor probes, and all necessary supplies.

Pulse oximeter sensor probes (procedure code A4606) for client-owned equipment are limited to 4 per month without prior authorization. Providers may obtain additional probes for clients birth through 20 years of age with documentation of medical necessity. Additional probes require prior authorization through CCP.
3.5.6 Donor Human Milk

3.5.6.1 Services/Benefits and Limitations
Donor human milk is a benefit of CCP for eligible THSteps clients who are birth through 11 months of age meeting all of the following criteria:

- The requesting physician has documented medical necessity and appropriateness.
- The parent or guardian has signed and dated an informed consent form indicating that the risks and benefits of using banked donor human milk have been discussed with them.
- The donor human milk bank adheres to quality guidelines consistent with the Human Milk Bank Association of North America or such other standards as may be adopted by HHSC.

Additional donor human milk benefits beyond the limitations listed above may be available to clients who are birth through 20 years of age with documentation of medical necessity.

Procedure code B9998 must be used when requesting or billing for human donor milk.

Donor human milk is reimbursed at a maximum fee determined by HHSC or manual pricing.

Donor human milk is only reimbursed to a Texas Medicaid enrolled donor milk bank and only for children who are in the home setting.

The physician must address the benefits and risks of using donor human milk, such as HIV, freshness, effects of pasteurization, nutrients, and growth factors to the parent. The physician also must address donor screening, pasteurization, milk storage, and transport of the donor milk. The physician may obtain this information from the donor milk bank.

3.5.6.2 Prior Authorization and Documentation Requirements
Donor human milk may be considered for a maximum of 6 months per authorization. The authorization may be extended with documentation of medical necessity.

Prior authorization is required for donor human milk provided through Texas Medicaid CCP Services. To obtain prior authorization, providers must complete the CCP Prior Authorization Request Form and a Donor Human Milk Request Form every 180 days. Both the ordering physician and the providing milk bank must maintain copies of the form in the client’s medical records.

The physician ordering the donor human milk must complete all of the fields in Part A of the original form, including the documentation of medical necessity. This information must be substantiated by written documentation in the clinical report. The physician must specify the quantity and the time frame in the Quantity Requested field (e.g., cubic centimeters per day or ounces per month). All of the fields in Part B of the form must be completed by the donor milk bank providing the donor human milk.

The prior authorization request and all completed documentation must be submitted to the TMHP CCP Prior Authorization Unit at:

Texas Medicaid & Healthcare Partnership
Comprehensive Care Program (CCP)
PO Box 200735
Austin, TX 78720-0735
Fax: 1-512-514-4212
The documentation of medical necessity and appropriateness and the signed and dated written informed consent form must be maintained in the client’s clinical records. The documentation of medical necessity must be completed by the physician ordering the donor human milk. The clinical records are subject to retrospective review. The documentation must address all of the following:

- Medical necessity, including why the particular client cannot survive and gain weight on any appropriate formula (e.g., elemental, special, or routine formula or food), or any enteral nutritional product other than donor human milk.
- A clinical feeding trial of an appropriate nutritional product has been considered with each authorization.
- The informed consent provided to the parent or guardian details the risks and benefits of using banked donor human milk.
- A copy of the CCP Prior Authorization Request Form and the Donor Human Milk Request Form.

Refer to: Form CH.5, “Donor Human Milk Request Form” in this handbook.

Form CH.1, “CCP Prior Authorization Request Form” in this handbook.

### 3.5.7 Electronic Blood Pressure Monitoring Device

#### 3.5.7.1 Services/Benefits and Limitations

An electronic blood pressure monitoring device is a benefit of CCP only in the home setting when:

- The client is 11 months of age or younger. (Coverage for clients 12 months of age or older may be considered upon review by HHSC or its designee with supporting documentation of medical necessity.)
- The client is CCP-eligible.
- The equipment is prescribed by a physician.
- Documentation is provided supporting medical necessity of the requested equipment.

An electronic blood pressure monitoring device is restricted to the following diagnosis codes. Other diagnoses can be considered upon review by HHSC or its designee.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4010 4011 4019 40200 40201 40210 40211 40290 40300 40301</td>
</tr>
<tr>
<td>40310 40311 40390 40391 40400 40401 40402 40403 40410 40411</td>
</tr>
<tr>
<td>40412 40413 40490 40491 40492 40493 40501 40509 40511 40519</td>
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<td>4150 41511 41512 41519 4160 4161 4162 4163 4164 4240</td>
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<tr>
<td>5880 58889 591 59371 59372 59373 7450 74510 74511 74512</td>
</tr>
<tr>
<td>74519 7452 7453 7454 7455 74560 74561 74569 7457</td>
</tr>
</tbody>
</table>

Procedure code E1399 is used to bill for the monthly rental of an electronic blood pressure monitoring device.
3.5.7.2 Prior Authorization and Documentation Requirements

Prior authorization is required for an electronic blood pressure monitoring device. A CCP Prior Authorization Request Form, signed and dated by the physician, must be submitted with the documentation supporting medical necessity for the device. Supporting documentation of medical necessity must include the diagnosis.

3.5.8 Incontinence Supplies for Clients Who Are Birth Through 3 Years of Age

3.5.8.1 Services/Benefits and Limitations

Incontinence supplies, such as diapers/briefs/pull-ons/liners, wipes, and underpads, may be considered for reimbursement through CCP for those clients who are birth through 3 years of age with a medical condition resulting in an increased urine and/or stool output beyond the typical output for this age group, such as celiac disease, short bowel syndrome, Crohn’s disease, thymic hypoplasia, AIDS, congenital adrenal hyperplasia, diabetes insipidus, Hirschsprung’s disease, or radiation enteritis.

Lack of bladder and/or bowel control is considered normal development up to 4 years of age.

Reusable diapers, briefs, pull-ons, liners, wipes, and underpads are not a benefit of CCP. Gloves used to change diapers, briefs, and pull-ons are not considered medically necessary unless the client has skin breakdown or a documented disease that may be transmitted through the urine.

Diaper wipes and underpads may be considered for clients who are receiving diapers, briefs, or pull-ons through CCP.

Skin sealants, protectants, moisturizers, and ointments may be considered for clients who have a documented medical condition that results in chronic incontinence and increased risk of skin breakdown.

External urinary collection devices, including, but not limited to, male external catheters, female collection devices, and related supplies, may be considered with a documented medical condition resulting in an increased urine and/or stool output beyond the typical output.

Providers must use the following procedure codes when billing for incontinence supplies for clients who are birth through 3 years of age:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4326</td>
<td>31 per month</td>
</tr>
<tr>
<td>A4327</td>
<td>4 per month</td>
</tr>
<tr>
<td>A4328</td>
<td>4 per month</td>
</tr>
<tr>
<td>A4335</td>
<td>2 per month</td>
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<tr>
<td>A4349</td>
<td>31 per month</td>
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<td>A4554</td>
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<tr>
<td>A6250</td>
<td>2 per month</td>
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<tr>
<td>T4521</td>
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<td>T4522</td>
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<tr>
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<tr>
<td>T4527</td>
<td>300 per month*</td>
</tr>
<tr>
<td>T4528</td>
<td>300 per month*</td>
</tr>
</tbody>
</table>
3.5.8.2 Prior Authorization and Documentation Requirements

Prior authorization is required for incontinence supplies through CCP.

A determination is made by HHSC or its designee as to the number of incontinence supplies prior authorized based on the client’s medical needs.

A combination of diapers, briefs, pull-ons, and liners may be considered for prior authorization for clients who are birth through 3 years of age and are limited to 300 per month.

To request prior authorization for incontinence supplies, the following documentation must be provided for the item(s) requested:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client’s overall health status
- Diagnosis/condition causing increased urination/stooling
- Client’s height, weight, and waist size
- Number of times per day the physician has ordered the supply be used
- Quantity of disposable supplies requested per month

3.5.9 Medical Nutritional Products

3.5.9.1 Services/Benefits and Limitations

Medical nutritional products for clients who are birth through 20 years of age are available only through CCP.

Medical nutritional products may be approved for clients who are CCP-eligible, birth through 20 years of age, and have specialized nutritional requirements. Medical nutritional products must be prescribed by a physician and be medically necessary. FFP for the medical nutritional product must also be available.

CCP will not cover the following:

- Nutritional products for clients that could be sustained on an age-appropriate diet
- Products traditionally used for infant feeding
- Pudding products (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product)
- Nutritional products for the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth (Documentation should describe the medical condition that led to these conditions.)
• Nutritional products for infants who are 11 months of age or younger unless medical necessity is documented and other criteria are met (A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.)

Generic medical nutritional products that have been approved by the U.S. Department of Agriculture (USDA) for use in the Special Supplemental Nutrition Program for WIC may be approved for use by CCP clients. Reimbursement is determined using the Red Book, less 10.5 percent. Reimbursement for products not listed in the Red Book is based on the same methodology using the average wholesale price (AWP) supplied by the manufacturer of the product. The provider is responsible for obtaining and submitting necessary product information with the request for products.

3.5.9.1.1 Enteral Nutritional Products

All enteral nutritional products paid under Texas Medicaid are paid based on units of 100 calories (as documented by the manufacturer) with the appropriate “B” code (as documented by the Pricing, Data Analysis, and Coding [PDAC] Product Classification List for Enteral Nutrition in effect at the time) and with the appropriate modifier based on the product’s AWP less 10.5 percent (as documented by the Red Book).

It is the provider’s responsibility to know the correct “B” code and the correct units of 100 calories when requesting prior authorization and payment. Supporting documentation for these components must be maintained in the provider’s records and be made available upon request by HHSC or its designee. The documentation must include number of cans delivered, number of ounces in each can, and number of calories in each can or how many ounces equal 100 calories, so substantiation of the units billed may be ascertained.

It is the provider’s responsibility to know when products are discontinued by the manufacturer, when container sizes change, and when names change. Submit requests for prior authorization and payment accordingly.

A written request must be submitted when using procedure code B9998 to request generic medical nutritional products that require prior authorization.

Procedure code B9998 can be submitted using one of the following modifiers: U1, U2, U3, U4, or U5. If procedure code B9998 is submitted without a modifier, it will be manually priced.

Note: The Pricing, Data Analysis, and Coding (PDAC) Product Classification List is located on the Noridian website at www.dmepdac.com.

3.5.9.2 Prior Authorization and Documentation Requirements

Prior authorization is not required for the following:

• Nutritional products developed for use in metabolic disorders for those clients with a documented metabolic disorder. (To be eligible for reimbursement, a claim must include the diagnosis indicating the metabolic disorder, and the nutritional product must be for use in metabolic disorders.)

• Nutritional products used for clients receiving part or all of their nutritional intake through a tube. Claims submitted for nutritional products not covered by CCP are denied. To be eligible for reimbursement, a claim must indicate the client has a feeding tube.

Mandatory prior authorization is required for any request that does not meet either of the above criteria. To request prior authorization, submit the CCP Prior Authorization Request Form and documentation to support medical necessity. Documentation must include the following:

• Height and weight

• Growth history

• Why the client cannot be maintained on an age-appropriate diet

• Other formulas tried and why they did not meet the client’s needs
Authorization may be given for up to 12 months.

Documentation that supports medical necessity must include one of the following:

- Identification of a metabolic disorder requiring a medically necessary nutritional product
- Indication that part or all nutritional intake is through a tube (e.g., nasogastric or gastrostomy/jejunostomy)
- Identification/explanation of the medical condition resulting in the requirement for a medical nutritional product

3.5.10 Mobility Aids

3.5.10.1 Services/Benefits and Limitations

Mobility aids and related supplies, including, but not limited to, strollers, special-needs car seats and travel safety restraints are a benefit to assist clients to move about in their environment. Mobility aids include, but are not limited to, the items detailed on the following pages.

Mobility aids and related supplies may be considered for reimbursement through CCP for clients who are birth through 20 years of age that are CCP-eligible when the following criteria are met:

- The equipment requested is medically necessary as supported in writing.
- FFP is available.
- The client’s mobility status would be compromised without the requested equipment.
- The requested equipment or supplies are safe for use in the home.

Mobility aids may be considered through CCP if the requested equipment is not available through Texas Medicaid (Title XIX) Home Health Services or the client does not meet criteria through Texas Medicaid (Title XIX) Home Health Services.

Mobility aid lifts for vehicles and vehicle modifications are not reimbursed through Texas Medicaid in accordance with federal regulations.

Note: Permanent ramps, vehicle ramps, and home modifications are not a benefit of Texas Medicaid.

3.5.10.1.1 Portable Client Lifts for Outside the Home Setting

Providers must use procedure code E0635 with modifier TG for the purchase of the portable client lift and is limited to once per lifetime, any provider. Portable electric lifts are a benefit of Texas Medicaid if they can fold-up for transport and can be used outside the home setting if the client must attend health-related services that require an overnight stay in a non-institutional setting.

3.5.10.1.2 Strollers (a multipositional client transfer system with integrated seat, operated by caregiver)

A stroller for medical needs may be considered under any of the following conditions:

- The client does not own another seating system, including, but not limited to, a wheelchair.
- The client’s condition does not require another type of seating system, including, but not limited to, a wheelchair.

If the client does not meet criteria for a stroller, a wheelchair may be considered through Texas Medicaid (Title XIX) Home Health Services.

A medical stroller does not have the capacity to accommodate the client’s growth. Strollers for medical use may be considered for prior authorization when all of the following criteria are met:

- The client weighs 30 pounds or more.
• The client does not already own another seating system, including, but not limited to, a standard or custom wheelchair.
• The stroller must have a firm back and seat, or insert.
• The client is expected to be ambulatory within 1 year of the request date or is not expected to need a wheelchair within 2 years of the request date.

3.5.10.1.3 Stroller Ramps—Portable and Threshold
A portable ramp is defined as a ramp that is able to be carried as needed to access a home and weighing no more than 90 pounds and/or measuring no more than 10 feet in length. A threshold ramp is defined as a ramp that provides access over elevated thresholds.

Portable ramps exceeding the above criteria may be considered on a case-by-case basis with documentation of medical necessity and a statement that the requested equipment is safe for use.

Ramps may be considered for rental for short-term disabilities. Ramps may be considered for purchase for long-term disabilities.

Providers must use procedure code E1399 for a portable and threshold stroller ramps.

3.5.10.1.4 Feeder Seats, Floor Sitters, Corner Chairs, and Travel Chairs
Feeder seats, floor sitters, corner chairs, and travel chairs are not considered medically necessary and are not a benefit of CCP. If a client requires seating support and meets the criteria for a seating system, a stroller may be considered for reimbursement with prior authorization through CCP, or a wheelchair may be considered through Texas Medicaid (Title XIX) Home Health Services.

3.5.10.1.5 Scooters
Scooters may be considered for reimbursement through Texas Medicaid (Title XIX) Home Health Services.

3.5.10.1.6 Mobility Aids – CCP HCPCS Procedure Codes and Limitations

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limitation</th>
</tr>
</thead>
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<tr>
<td>97001</td>
<td>As needed</td>
</tr>
<tr>
<td>97003</td>
<td>As needed</td>
</tr>
<tr>
<td>E0700*</td>
<td>Two purchases per year</td>
</tr>
<tr>
<td>E1035*</td>
<td>One purchase per 5 years</td>
</tr>
<tr>
<td>E1037</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>E1399*</td>
<td>One purchase per 5 years</td>
</tr>
<tr>
<td>K0739*</td>
<td>As needed</td>
</tr>
<tr>
<td>L1500*</td>
<td>One purchase per 5 years</td>
</tr>
<tr>
<td>L1510*</td>
<td>One purchase per 5 years</td>
</tr>
<tr>
<td>L1520*</td>
<td>One purchase per 5 years</td>
</tr>
</tbody>
</table>

* Procedure codes that require prior authorization

3.5.10.2 Prior Authorization and Documentation Requirements
Prior authorization is required for all mobility aids and related services, except travel safety restraints, for clients with a medical condition requiring them to be transported in either a prone or supine position.
Mobility aid equipment that has been purchased is anticipated to last a minimum of 5 years and may be considered for replacement with prior authorization when 5 years have passed and/or the equipment is no longer repairable. Prior authorization for replacement of mobility aid equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent recurrence must be submitted.

When prior authorization of a mobility aid replacement is requested before 5 years have passed, the following information must be submitted with the request:

- A statement from the prescribing physician or licensed occupational therapist (OT) or PT
- Documentation supporting why the equipment no longer meets the client’s needs

HHSC or its designee determines whether the equipment is rented, purchased, repaired, or modified based on the client’s needs, duration of use, and age of equipment.

Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

3.5.10.2.1 Portable Client Lifts for Outside the Home Setting

Prior authorization is required and will be considered on a case-by-case basis for portable client electric lifts that can fold-up for transport and that are necessary for use outside the home setting.

The provider must submit a prior authorization request with the following documentation for consideration of medical necessity:

- An explanation of why a home-based portable lift will not meet the client’s needs.
- A description of the circumstances, including duration of need, when the client is required to attend health-related services requiring an overnight stay in a non-institutional setting.
- The family member or caregiver(s) supporting the client in the use of the portable client lift when required to travel outside the home setting for health-related visits.

3.5.10.2.2 Strollers (a multipositional client transfer system with integrated seat, operated by caregiver)

A seating assessment must be completed by a physician or licensed OT or PT, who is not employed by the equipment supplier, before requesting prior authorization. If the seating assessment is completed by a physician, reimbursement is considered part of the physician’s office visit and is not prior authorized. Other providers must use procedure codes 97001 and 97003 when billing for a seating evaluation.

The seating assessment must:

- Explain how the family will be trained in the use of the equipment.
- Anticipate changes in the client’s needs and include anticipated modifications or accessory needs, as well as the anticipated width of the medical stroller to allow client growth with use of lateral/thigh supports.
- Include significant medical information pertinent to the client’s mobility and how the requested equipment will accommodate these needs, including intellectual, postural, physical, sensory (visual and auditory), and physical status.
- Address trunk and head control, balance, arm and hand function, existence and severity of orthopedic deformities, any recent changes in the client’s physical and/or functional status, and any expected or potential surgeries that will improve or further limit mobility.
- Include information on the client’s current mobility/seating equipment, how long the client has been in the current equipment, and why it no longer meets the client’s needs.
• Include the client’s height, weight, and a description of where the equipment is to be used. Seating measurements are required.

• Include information on the accessibility of client’s residence.

• Include manufacturer’s information, including the description of the specific base, any attached seating system components, and any attached accessories.

To request prior authorization for the purchase of procedure code E1035, the criteria must be met for the level of stroller requested:

• Level One: Basic Stroller. The client meets the criteria for a stroller. Providers must use procedure code E1035.

• Level Two: Stroller with Tray for Oxygen and/or Ventilator. The client meets the criteria for a level-one stroller and is oxygen- or ventilator-dependent. Providers must use procedure code E1035 with modifier TF.

• Level Three: Stroller with Positioning Inserts. The client meets the criteria for a level-one or level-two stroller and requires additional positioning support. Providers must use procedure code E1035 with modifier TG.

The following supporting documentation must be submitted:

• A completed Wheelchair/Stroller Seating Assessment Form CH.19 that includes documentation supporting medical necessity. This documentation should address why the client is unable to ambulate a minimum of 10 feet due to his/her condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy), or if able to ambulate further, why a stroller is required to meet the client’s needs.

• If the client is 3 years of age or older, documentation must support that the client’s condition, stature, weight, and positioning needs allow adequate support from a stroller.

  Note: A stroller may be considered on a case-by-case basis with documentation of medical necessity for a client who does not meet the criteria listed above.

3.5.10.2.3 Stroller Ramps—Portable and Threshold

One portable and one threshold ramp for stroller access may be considered for prior authorization when documentation supports medical necessity and includes the following:

• The date of purchase and serial number of the client’s medical stroller or documentation of a medical stroller request being reviewed for purchase

• Diagnosis with duration of expected need

• A diagram of the house showing the access point(s) with the ground-to-floor elevation and any obstacles

A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Ramps may be considered for rental for short-term disabilities. Ramps may be considered for purchase for long-term disabilities.

Mobility aid lifts for vehicles and vehicle modifications are not reimbursed through Texas Medicaid according to federal regulations.

  Note: Permanent ramps, vehicle ramps, and home modifications are not a benefit of Texas Medicaid.
3.5.11 Pediatric Hospital Cribs/Enclosed Beds/Reflux Wedges and Slings

3.5.11.1 Services/Benefits and Limitations
Pediatric hospital cribs, enclosed beds, reflux wedges, and slings (procedure codes E0300, E0316, E1399, and K0739) may be considered under CCP.

The purchase of a safety enclosure frame/canopy/bubble top (procedure code E0316) may be a benefit when the protective crib top/bubble top is for safety use. It is not considered a benefit when it is used as a restraint or for the convenience of family or caregivers.

Procedure code E1399 may be used for pediatric hospital cribs that are not enclosed, reflux wedges, or reflux slings.

Enclosed bed systems that are not approved by the Food and Drug Administration (FDA) are not a covered benefit.

Non-pediatric hospital cribs/enclosed beds can be considered through Texas Medicaid (Title XIX) Home Health Services.

Reflux slings or wedges may be considered for clients who are birth through 11 months of age. Reflux slings or wedges may be used as positioning devices for infants who require elevation after feedings when prescribed by a physician as medically necessary and appropriate.

3.5.11.2 Prior Authorization and Documentation Requirements
Pediatric hospital cribs, enclosed beds, reflux wedges, and slings (procedure codes E0300, E0316, E1399, and K0739) may be considered under CCP with prior authorization.

To be considered for prior authorization, the provider must include all of the following to support medical necessity:

- The diagnosis, medical needs, treatments, developmental level, and functional skills of the child. A diagnosis alone is insufficient information to consider prior authorization of the requested equipment.
- The age, length, and weight of the child.
- A description of any other devices that have been used, the length of time used, and why they were ineffective.
- How the requested equipment will correct or ameliorate the client’s condition beyond that of a standard child’s crib, regular bed, or standard hospital bed.
- The name of the manufacturer and the manufacturer’s suggested retail price (MSRP).

A determination will be made by HHSC or its designee whether the equipment will be rented, purchased, repaired, or modified based on the client’s needs, duration of use, and age of equipment.

3.5.12 Phototherapy Devices

3.5.12.1 Services/Benefits and Limitations
The rental of phototherapy devices (procedure code E0202) for use in the home are a benefit of Texas Medicaid for low-risk infants.
Low-risk infants are 35 or more weeks gestation at birth, without comorbidity, and with a total serum bilirubin (TSB) level within the following ranges:

<table>
<thead>
<tr>
<th>Infant's Gestation at Birth</th>
<th>TSB for infant 0-24 hours of age</th>
<th>TSB for infant 25-48 hours of age</th>
<th>TSB for infant 49-72 hours of age</th>
<th>TSB for infant older than 72 hours of age</th>
</tr>
</thead>
<tbody>
<tr>
<td>35-37 weeks</td>
<td>3-7</td>
<td>7-13</td>
<td>10-15</td>
<td>13-18</td>
</tr>
<tr>
<td>38 weeks or greater</td>
<td>6-11</td>
<td>12-15</td>
<td>15-18</td>
<td>18-21</td>
</tr>
</tbody>
</table>

TSB levels are expressed in milligrams per deciliter (mg/dl).

Consideration for the rental of a home phototherapy device includes, but is not limited to, the following primary diagnoses:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>7740</td>
</tr>
<tr>
<td>7741</td>
</tr>
<tr>
<td>7742</td>
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<tr>
<td>77430</td>
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<tr>
<td>77431</td>
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<tr>
<td>77439</td>
</tr>
<tr>
<td>7744</td>
</tr>
<tr>
<td>7745</td>
</tr>
<tr>
<td>7746</td>
</tr>
<tr>
<td>7747</td>
</tr>
</tbody>
</table>

The DME provider must perform routine maintenance and provide instructions to the parent or guardian on the safe use of the phototherapy device. Rental of a phototherapy device is reimbursed as a daily global fee and is limited to one per day per client any provider.

Providers may not bill for those days the phototherapy device is at the client’s home and is not in use.

Skilled nursing visits for clients requiring phototherapy services may be reimbursed separately through Title XIX Home Health Services for nonroutine clinical teaching and assessment. Routine laboratory specimens are obtained during the skilled nursing visit, and may only be considered when the alternative to obtaining the specimen is to transport the client by ambulance.

If a client that is receiving private duty nursing (PDN) services requires phototherapy, instructions in the use of the equipment must be part of the existing PDN authorized hours. Skilled nursing visits will not be allowed on the same day as PDN services.

In accordance with AAP guidelines, providers must conduct ongoing assessments for risk of severe hyperbilirubenemia for all infants who receive home phototherapy.

Initiation of home phototherapy for medium- and high-risk infants is not a benefit of Texas Medicaid. As defined by the AAP, medium- and high-risk infants should be considered for more extensive initial treatment in an inpatient setting. Medium- and high-risk infants include, but are not limited to, those who have one of the following known risk factors:

- Acidosis
- Albumin less than 3.0 g/dl
- Asphyxia
- Glucose-6-phosphate dehydrogenase (G6PD) deficiency
- Isoimmune hemolytic disease (blood group incompatibility)
- Jaundice within the first 24 hours
- Sepsis
- Significant lethargy
- Temperature instability
3.5.12.2 Prior Authorization and Documentation Requirements

Home phototherapy devices require prior authorization and are provided only for the days that are medically necessary.

For low-risk infants, prior authorization will be considered for phototherapy services that begin in the home.

For stabilized infants who began phototherapy treatment during their hospitalization and have been discharged from the hospital, prior authorization will be considered for the continuation of phototherapy services in the home. Initial prior authorization may be given for a maximum of 7 days of home phototherapy. A new "CCP Prior Authorization Request Form" must be submitted to request more than 7 days of home phototherapy.

The following documentation is required to support medical necessity when requesting home phototherapy services:

- A diagnostic evaluation, which should include, but is not limited to, a normal history and physical exam, and normal laboratory values for the following, as medically indicated:
  - Complete blood count with differential
  - Platelets
  - Blood smear for red blood cell morphology
  - Reticulocyte count
  - Urinalysis
  - Maternal and infant blood typing
  - Coombs test
  - TSB (in mg/dl)
  - Gestational age
  - Documentation of adequate infant hydration, as demonstrated by 4-6 wet diapers per day and 3-4 stools per day
  - Documentation stating that infant weight loss does not exceed 10% of the infant’s birth weight
  - Physician’s plan of care
  - Anticipated number of days the client will need the phototherapy treatment
  - Documentation of parental education regarding the importance of monitoring and follow-up

When requesting prior authorization for a hospitalized infant that requires continued home phototherapy, providers must submit documentation that indicates all pre-existing medium- or high-risk factors have resolved or stabilized.

Providers must submit the following additional documentation for prior authorization requests for previously hospitalized infants that require continued home phototherapy or for more than 7 days of home phototherapy:

- TSB level greater than 13 mg/dl and trending downward. TSB levels less than 13 will require medical review to determine medical necessity.

**Note:** According to AAP guidelines, phototherapy may be discontinued when the TSB level falls below 13–14 mg/dl; however, exceptions to the guidelines may be considered. As a result, documentation must include the rationale for not discontinuing phototherapy when the TSB level drops below 13 mg/dl.
• Birth weight and current weight demonstrating weight gain.

Note: According to AAP guidelines, breastfed infants are expected to gain 15-30 grams per day (1/2-1 ounce per day) through the first 2-3 months of life.

3.5.12.2.1 Retroactive Eligibility
Newborn babies may not have a Medicaid number at the time that services are ordered by the physician and provided by the supplier. In these cases, prior authorization may be given retroactively for services rendered between the start date and the date that the client’s Medicaid number becomes available.

• The provider is responsible for finding out the effective dates of client eligibility.

• The provider has 95 days from the date on which the client’s Medicaid number becomes available (add date) to obtain prior authorization for services that were already rendered.

3.5.13 Special Needs Car Seats and Travel Restraints

3.5.13.1 Services/Benefits and Limitations

3.5.13.1.1 Special Needs Car Seats
A special needs car seat must have a top tether installed. The top tether is essential for proper use of the car seat. The installer is reimbursed for the installation by the manufacturer.

Providers must use procedure code E1399 for a special needs car seat.

Car seat accessories available from the manufacturer may be considered for reimbursement with prior authorization when medically necessary for correct positioning.

A stroller base for a special needs car seat is not a benefit of Texas Medicaid.

3.5.13.1.2 Travel Safety Restraints
Providers must use procedure code E0700 for the purchase of travel safety restraints, such as ankle and wrist belts.

3.5.13.2 Prior Authorization and Documentation Requirements

3.5.13.2.1 Special Needs Car Seats
A special needs car seat may be considered for reimbursement with prior authorization for a client who has outgrown an infant car seat and is unable to travel safely in a booster seat or seat belt. Consideration should be given to the manufacturer’s weight and height limitations and must reflect allowances for at least 12 months of growth.

The provider must maintain a statement that has been signed and dated by the client’s parent or legal guardian in the client’s medical record that states the following:

• A top tether has been installed in the vehicle in which the client will be transported, by a manufacturer-trained vendor.

• Training in the correct use of the car seat has been provided by a manufacturer-trained vendor.

• The client’s parent or legal guardian has received instruction and has demonstrated the correct use of the car seat to a manufacturer-trained vendor.

To request prior authorization for a special needs car seat or accessories, the following criteria must be met:

The client’s weight must be at least 40 pounds, or the client’s height must be at least 40 inches.
Supporting documentation must include the following and must be submitted for prior authorization:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client’s overall health status.
- A description of the client’s postural condition specifically including head and trunk control (or lack of control) and why a booster chair or seatbelt will not meet the client’s needs (the car seat must be able to support the head if head control is poor).
- The expected long-term need for the special needs car seat.
- A copy of the manufacturer’s certification for the installer’s training to insert the specified car seat.

A request for a client who does not meet the criteria may be considered on a case-by-case basis on review by HHSC or its designee.

3.5.13.2.2 Travel Safety Restraints

A travel safety restraint and ankle or wrist belts may be considered for reimbursement through CCP without prior authorization for clients with a medical condition requiring them to be transported in either a prone or supine position. The DME provider and the prescribing physician familiar with the client must maintain documentation in the client's medical record supporting the medical necessity of the travel safety restraint.

3.5.14 Claims Information

Claims for DME must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 claims form. Providers may purchase CMS-1500 claims from the vendor of their choice. TMHP does not supply the forms.

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

Section 6, Claims Filing (Vol. 1, General Information) for general information about claims filing.


3.5.15 Reimbursement

DME and expendable medical supplies are reimbursed in accordance with 1 TAC §355.8441. See the applicable fee schedule on the TMHP website at www.tmhp.com.

3.6 Medical Nutrition Counseling Services (CCP)

3.6.1 Enrollment

Independently practicing licensed dietitians may enroll in Texas Medicaid to provide services to THSteps-eligible clients. Dieticians who provide nutrition assessments and counseling must be currently licensed by the Texas State Board of Examiners of Dietitians in accordance with the Licensed Dietitians Act, Chapter 701, Texas Occupations Code.

Refer to: Subsection 3.2.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.

3.6.2 Services/Benefits and Limitations

Only providers enrolled as licensed dietitians are eligible for reimbursement for nutrition therapy and counseling services.
Medical nutrition therapy (assessment, reassessment, and intervention) and medical nutrition counseling may be beneficial for treating, preventing, or minimizing effects of illness, injuries, or other impairments.

Medical nutrition counseling services are a benefit when all of the following criteria are met:

- The client is eligible for CCP.
- The services are prescribed by a physician.
- Clinical documentation supports medical necessity and medical appropriateness.
- The services are performed by a Medicaid-enrolled dietitian licensed by the Texas State Board of Examiners of Dietitians.
- Federal financial participation is available.

Medical nutrition therapy (procedure codes 97802, 97803, and 97804) and nutrition counseling (procedure code S9470) may be considered beneficial for disease states for which dietary adjustment has a therapeutic role. The disease states include, but are not limited to, the following conditions:

- Cardiovascular disease
- Diabetes or alterations in blood glucose
- Hypertension
- Kidney disease
- Eating disorders
- Abnormal weight gain
- Gastrointestinal disorders
- Lack of normal weight gain
- Nutritional deficiencies
- Inherited metabolic disorders

Nutritional intervention for chronic fatigue syndrome, attention-deficit hyperactivity disorder, idiopathic environmental intolerances, and multiple food and chemical sensitivities is considered experimental and investigational and is not a benefit.

Medical nutrition counseling services for the diagnosis of obesity without a comorbid condition is not a benefit.

Providers are responsible for maintaining documentation to support medical necessity in the client’s medical record.

Medical nutrition therapy (procedure codes 97802 and 97803) are limited to 4 units (1 unit = 15 minutes) per rolling year. Dietitian visits for nutrition counseling (procedure code S9470) are limited to 2 visits per rolling year. Medical nutrition group therapy (procedure code 97804) is not a benefit in the home setting and is limited to 8 units (1 unit = 30 minutes) per rolling year.

Procedure code S9470 is a less comprehensive service, and does not include an assessment or reassessment.

Procedure codes 97803 and 97804 will be denied as part of another service when submitted by any provider on the same date of service as procedure code 97802. Procedure code 97804 will be denied as part of another service when submitted by any provider on the same date of service as procedure code 97803. Procedure code S9470 will be denied as part of another service when submitted by any provider on the same date of service as procedure code 97802, 97803 or 97804.
A case manager, school counselor, or school nurse may refer a client for medical nutrition group therapy. Participation in medical nutrition group therapy is optional. A prescription from a physician is required, and informed consent must be obtained from the client’s parent or guardian before rendering services. The medical documentation maintained in the client’s medical record must include the following:

- Physician prescription
- Medical nutrition counseling service provided
- Goals or objectives for the group therapy
- Client participation
- Beginning and ending time of the group therapy session

Group therapy may be provided to a group of clients (minimum of two and maximum of ten) with the same condition. While medical nutrition group therapy must be led by a Medicaid-enrolled dietitian licensed by the Texas State Board of Examiners of Dietitians, other health-care providers may participate in the group sessions. The focus of the therapy is nutrition and health for chronic conditions such as the following:

- Acquired acanthosis nigricans
- Diabetes
- Dysmetabolic syndrome X
- Eating disorder
- Hyperlipidemia
- Other specified hypoglycemia
- Pure hypercholesterolemia
- Pure hyperglyceridemia

Medical nutrition group therapy must last at least 30 minutes and should include:

- An age-appropriate presentation on nutrition issues related to the chronic condition. The presentation may include information about prevention of disease exacerbation or complications and living with chronic illness. The presentation may also offer suggestions for making healthy food choices or changing ideas about food.
- A question and answer period.

### 3.6.3 Prior Authorization and Documentation Requirements

Prior authorization is required for services exceeding the limitations for medical nutrition therapy (assessment, reassessment and intervention), nutrition group therapy, and nutrition counseling visits.

The following documentation must be submitted to the CCP Prior Authorization Unit for prior authorization:

- Completed CCP Prior Authorization Request Form
- Diagnosis of a condition for which there is medical necessity for the service
- Treatment plan
- Obstacles for not meeting goals
- Interventions planned to meet goals
The prescribing physician and provider must maintain documentation of medical necessity, including the completed CCP Prior Authorization Request Form, in the client's medical record. The physician must maintain the original signed copy of the CCP Prior Authorization Request Form. The completed CCP Prior Authorization Request Form is valid for a period of up to 6 months from the date of the physician signature.

### 3.6.4 Claims Information

Providers must submit services provided by licensed dietitians in an approved electronic claims format or on a CMS-1500 paper claim form from the vendor of their choice. TMHP does not supply the forms.

Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 Claim Form or its equivalent.

Refer to:
- Section 3, TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.
- Section 6, Claims Filing (Vol. 1, General Information) for general information about claims filing.
- Form CH.28, “Medical Nutritional Counseling (CCP Only)” in this handbook for a claim form example.

### 3.6.5 Reimbursement

Dietitian services are reimbursed in accordance with 1 TAC §355.8441.

### 3.7 Orthotic and Prosthetic Services (CCP)

#### 3.7.1 Enrollment

To be eligible to participate in CCP, providers of orthotics and prosthetics services must be enrolled in Medicare.

Texas Medicaid enrolls and reimburses orthot and prosthetic suppliers only for CCP services and Medicare crossovers. The information in this section is applicable to CCP services only.

Refer to: Subsection 3.2.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.

#### 3.7.2 Services/Benefits and Limitations

Orthotics and prosthetics are a covered benefit of CCP for clients who require medically necessary orthotics or prosthetics that are prescribed by a physician (MD or DO) or a podiatrist (for ankle and foot orthotics). Orthotic devices, provided to ICF-MR clients and clients who reside in a nursing facility, are a benefit of CCP. Payment is made directly to the vendor. The equipment belongs to the client or family. Non-orthotic devices, such as a knee immobilizer, are not a benefit for nursing facility residents and ICF-MR clients.

Orthoses and prostheses must be dispensed, fabricated, and modified by an approved orthotist or orthotist/prosthetist.

Other orthoses and prostheses devices and services not listed in this section may be covered.

#### 3.7.2.1 Replacement of Orthoses/Prostheses

Replacement of an orthotic/prosthetic device is considered when loss or irreparable damage has occurred. A copy of the police or fire report is required when appropriate, along with the measures to be taken to prevent recurrence or similar loss. Supporting medical documentation is required for the
replacement of an orthotic or prosthetic device if less than 6 months from the actual date the client received the device. If less than 1 year since initial purchase, the request for replacement is referred to the medical director for review.

### 3.7.2.2 Training in Using the Orthotic or Prosthetic Device

Training in the use of an orthotic or prosthetic device for a client who has not worn one previously, has not worn one for a prolonged period, or is receiving a different type may be reimbursed when the training is provided by a physical or occupational therapist.

### 3.7.3 Prior Authorization and Documentation Requirements

All requests for prior authorization or claim reimbursement must:

- Be for orthotic or prosthetic devices prescribed by a physician (MD or DO) or a podiatrist. A podiatrist prescription is valid for conditions of the ankle and foot. The prescription is placed on file for a time period not to exceed 12 months. At the end of the prescription period, a prior authorization is required for any repairs, replacement parts, devices, or supplies.
- Contain a prescription dated before the date of service. The date of service must be within 3 months of the prescription date. The service is considered “provided” on the date the supplier has placed an order for the equipment and has incurred liability for the equipment.
- Include accurate diagnostic information pertaining to the orthotic/prosthetic device requested.
- Explain the medical necessity of the orthotic or prosthetic requested. A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.
- Be for orthotic devices provided by a currently licensed orthotist or prosthetist enrolled with Medicare and CCP. **Exception:** upper extremity splints made with low temperature materials and inhibitive casting may be provided by OTs or PTs.
- Be for prosthetic devices provided by a currently licensed prosthetist or orthotist/prosthetist.

Requests for prior authorization must be filed using a CCP Prior Authorization Request Form completed by the treating physician.

Requests for prior authorization and reimbursement of single items exceeding the $1,500 allowable amount must be supported by written documentation demonstrating medical necessity.

The DOS for a custom-made or fitted orthosis is the date the supplier places an order for the equipment and incurs liability for the equipment. For a recipient who has lost eligibility, custom-made orthotic devices may be reimbursed when the DOS occurred during a month the client was eligible for Medicaid.

### 3.7.3.1 Repairs, Modifications, and Fittings of Orthosis/Prostheses

Repairs due to regular wear and modifications due to growth or change in medical status are a benefit when proven more cost-effective than replacing the device. Additional information from the provider may be requested to determine cost-effectiveness.

Prior authorization is required for repairs, modifications, and fittings. Documentation supporting medical necessity must be provided when requesting prior authorization.

Reimbursement of fittings is considered included in the regular reimbursement fee, except in situations such as parapodiums, where time spent at fitting may be extensive. Fitting for parapodiums must be prior authorized.

For repairs, modifications, and fittings to an orthosis, providers must bill using procedure codes K0739, L4205, and L4210.

If prior authorization is not requested, submit documentation to support medical necessity with each claim and include a prescription signed by a physician (MD or DO).
A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

### 3.7.4 Cranial Molding Orthotics

#### 3.7.4.1 Services/Benefits and Limitations

Cranial molding orthotics may be a benefit when the following applies:

- The cranial molding orthotics are part of a treatment plan for shaping the skull in cases of post-operative plagiocephaly with synostosis or positional plagiocephaly with an associated functional impairment (or risk thereof).

- Documentation exists that the use of the cranial molding orthotic will modify or prevent the development of such impairment, including orofacial and musculoskeletal disorder, for clients who are 3 through 18 months of age.

Muscular torticollis (wry neck) characterized by tight or shortened neck muscles that result in a head tilt or turn is often associated with the secondary development of positional plagiocephaly. Clients with positional plagiocephaly and muscular torticollis must have documentation of early, aggressive treatment (stretching, positioning, and/or physiotherapy) before consideration for cranial orthosis.

Requests for clients with a comorbid diagnosis that prohibits repositioning will be evaluated on an individual basis.

Cranial molding orthotics may be reimbursed using procedure code S1040.

#### 3.7.4.2 Prior Authorization and Documentation Requirements

Cranial molding orthotics may only be considered for prior authorization when they are part of a treatment plan for shaping the skull in cases of post-operative plagiocephaly with synostosis or positional plagiocephaly with an associated functional impairment and documentation that the use of the cranial molding orthotic will modify or prevent the development of such impairment, including orofacial and musculoskeletal disorder.

Cranial molding orthotics when used as a treatment of plagiocephaly without synostosis is considered cosmetic, not medically necessary, and therefore not a benefit of Texas Medicaid.

The definition for cosmetic, as it applies to cranial molding orthotics, includes surgery or other services used primarily to improve appearance and not to restore or correct significant deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic process.

Requests for cranial molding orthotics will be considered for prior authorization for use after surgery for cranial deformities, including craniostenosis. Cranial molding orthotics may be considered as a benefit of the Medicaid Program when included as part of a treatment plan to reshape a skull deformity due to pathologic processes.

Cranial molding orthotics must be prior authorized for reimbursement through CCP with documentation supporting medical necessity. Written documentation must include:

- The assessment and recommendations of the appropriate primary care physician, pediatric subspecialist, craniofacial team, or pediatric neurosurgeon.

- A full description of the physical findings, precise diagnosis, age of onset, and the etiology of the deformity.

- Reports of any radiological procedures used in making the diagnosis.

- Documentation that the client is at least 3 months of age but not greater than 18 months of age.

- Anthropometric measurements documenting greater than 10 mm of cranial asymmetry.
• For clients 5 months of age or younger, documentation of aggressive repositioning, with or without physical therapy, of at least 3 months’ duration without improvement in cranial asymmetry.

  Note: Due to the mobility of children 6 months of age or older and the limited timeframe during which the device may be effective, repositioning is not indicated in this age group.

• Plan of treatment and or follow-up schedule

Prior authorization is denied when pricing is not included with the CCP Prior Authorization Form.

3.7.5 Corrective Shoe, Wedge, and Lift

3.7.5.1 Services/Benefits and Limitations

3.7.5.1.1 Corrective Shoes

Corrective shoes must be prescribed by a licensed physician (MD or DO) or a podiatrist. Corrective shoes are limited to one pair of corrective shoes every 3 years. Two pairs of shoes may be purchased at the same time; however, in such situations additional requests for shoes are not considered for another 6 months.

A corrective shoe does not include tennis shoes (even if prescribed by a physician and worn with a removable brace).

A corrective shoe does not include a shoe insert when it is not part of a modified shoe or when the shoe in which it is inserted is not attached to a brace (other than procedure code L3000).

Only 1 pair of corrective shoes can be authorized every 3 months. Two pairs of shoes may be purchased at the same time; however, in such situations additional requests for shoes are not considered for another 6 months.

3.7.5.1.2 Wedge and Lift

Wedges and lifts must be prescribed by a licensed physician (MD or DO) or a podiatrist. A wedge or lift must be for unequal leg length greater than one-half inch. Reimbursement may include the cost of the prescription shoe.

3.7.5.2 Prior Authorization and Documentation Requirements

CCP may authorize and reimburse prescription shoes (corrective/orthopedic), wedges, and lifts. The prior authorization request and reimbursement must meet the following requirements:

3.7.5.2.1 Corrective Shoes

Corrective shoes will be considered for prior authorization when one of the following criteria is met:

• Permanently attached to a brace
• Custom modified by an orthotist or orthotist/prosthetist at the direction of the prescribing physician
• Necessary to hold a surgical correction, postoperative casting, or serial/clubfoot casting. The corrective shoe may be authorized up to 1 year post procedure

  Note: Corrective shoes that are not attached to a brace require prior authorization.

Requests for corrective shoes that do not meet the criteria listed above may be submitted with the appropriate documentation to medical review for consideration.

3.7.5.2.2 Wedges and Lifts

A wedge or lift must be for unequal leg length greater than one-half inch.
3.7.6 Dynamic Splint
3.7.6.1 Services/Benefits and Limitations
Dynamic Splints are a benefit through CCP.

3.7.6.2 Prior Authorization and Documentation Requirements
Requests for dynamic splints may be prior authorized when submitted for medical review with the following documentation supporting medical necessity:

- Client's condition
- Client's current course of therapy
- Rationale for the use of the dynamic splint
- Likelihood that the family and client will comply with the prescribed use of the dynamic splint

3.7.7 Protective Helmets
3.7.7.1 Services/Benefits and Limitations
Protective helmets are a benefit through CCP. Providers may use procedure codes A8000, A8001, A8002, A8003 or A8004 when billing for protective helmets.

3.7.7.2 Prior Authorization and Documentation Requirements
Protective helmets require prior authorization and may be considered for reimbursement for neoplasm of the brain, subarachnoid hemorrhage, epilepsy, or cerebral palsy.

All requests for diagnoses other than those listed above require submission of documentation of medical necessity. A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

3.7.8 Reciprocating Gait Orthoses (RGO)
3.7.8.1 Services/Benefits and Limitations
RGO are a benefit through CCP for children with spina bifida or similar functional disabilities.

3.7.8.2 Prior Authorization and Documentation Requirements
RGO may be prior authorized for clients with spina bifida or similar functional disabilities. The prior authorization request must include a statement from the prescribing physician indicating the medical necessity, PT plan, and information that the family is expected to comply with the treatment plan.

3.7.9 Removable Shoe Insert, UCB (University of California at Berkeley) Type
3.7.9.1 Services/Benefits and Limitations
Shoe inserts are not a benefit when they are not part of a modified shoe or when the shoe in which they are inserted is not attached to a brace, with the exception of the UCB removable shoe insert.

Procedure code L3000 may be payable when billing for a removable foot insert.

3.7.9.2 Prior Authorization and Documentation Requirements
A UCB removable shoe insert may be prior authorized and reimbursed when the service meets one of the following:

- Client has a valgus deformity and significant congenital pes planus (75461) with pain.
- Client has a structural problem which results in significant pes planus, such as Down syndrome.
- Client has acute plantar fasciitis.
3.7.10 Thoracic-Hip-Knee-Ankle Orthoses (THKAO) (Vertical or Dynamic Standers, Standing Frames/Braces, and Parapodiums)

3.7.10.1 Services/Benefits and Limitations

THKAO (vertical or dynamic standers, standing frames or braces, and parapodiums), including all accessories, require prior authorization. A THKAO may be considered if the client requires assistance to stand and remain standing. A THKAO is not considered for prior authorization if the client already owns a stander (other than a vertical stander or standing frame or brace) or gait trainer.

3.7.10.1.1 Parapodium

A parapodium is used to help clients with neuromuscular diseases/conditions resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free. It helps develop a sense of balance and aids in learning functional movements such as standing with the hands free. A parapodium acts as an exoskeleton, providing side struts and chest, hip, knee, and foot bracing.

A parapodium may be considered for reimbursement for one of the following levels:

- **Level One: Small Parapodium.** The client has a maximum axillary height of 35 inches and a maximum weight of 55 pounds (normal age range is 1 through 10 years of age). Providers must use procedure code L1500 or L1520.
- **Level Two: Medium parapodium.** The client has a maximum axillary height of 41 inches and a maximum weight of 77 pounds (normal age range is 5 through 12 years of age). Providers must use procedure code L1500-TF or L1520-TF.
- **Level Three: Large parapodium.** The client has a maximum axillary height of 45 inches and a maximum weight of 115 pounds (normal age range is 10 through 16 years of age). Providers must use procedure code L1500-TG or L1520-TG. Labor for parapodium assembly may be prior authorized.

3.7.10.1.2 Standing Frame or Brace

A standing frame or brace is used to help very young clients, 12 months of age or older, who have good head control in the upright position and who have a neuromuscular disease/condition resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free.

Providers must use procedure code L1510 for a standing frame or brace.

3.7.10.1.3 Vertical or Dynamic Stander

A vertical stander or dynamic stander is used to initiate standing for clients who cannot maintain a good standing posture or may never be able to stand independently. A vertical stander is used to develop weight bearing through the legs in order to decrease demineralization and to promote better body awareness. Documentation for these standers must address medical necessity for the standers to be mobile.

Providers must use procedure code L1510 for a vertical stander. Providers must use procedure code E0642 for the purchase of a dynamic stander.

3.7.10.2 Prior Authorization and Documentation Requirements

THKAO (vertical or dynamic standers, standing frames/braces, and parapodiums), including all accessories, requires prior authorization.

THKAO may be considered if the client requires assistance to stand and remain standing. A THKAO will not be considered if the client already owns a stander (other than a vertical stander or standing frame/brace) or gait trainer.

Prior authorization may be considered for the THKAOs with the following documentation:

- Diagnoses relevant to the requested equipment, including functioning level and ambulatory status
• Anticipated benefits of the equipment
• Frequency and amount of time of a standing program
• Anticipated length of time the client will require this equipment
• Client’s height/weight/age
• Anticipated changes in the client's needs, anticipated modifications, or accessory needs, as well as the growth potential of the stander

3.7.11 Claims Information
Submit services provided by orthotic and prosthetic suppliers in an approved electronic format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

Important: Attach the invoice to the claim for any specialized equipment.

Include the name of the referring physician in Block 17 of CMS-1500 paper claim form or its electronic equivalent. Orthotics or prosthetics may be billed in the office, home, or outpatient setting. Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 paper claim form or its electronic equivalent.

Refer to: Form CH.30, “Orthotic and Prosthetic Services (CCP Only)” in this handbook for a claim form example.

3.7.12 Reimbursement
Orthotic and prosthetic services are reimbursed in accordance with 1 TAC §355.8441. Outpatient hospitals are reimbursed for THSteps DME and expendable supplies in accordance with 1 TAC §355.8061.

3.8 Personal Care Services (PCS) (CCP)
3.8.1 Enrollment
CCP providers that want to participate in the delivery of PCS to Medicaid clients must be enrolled with TMHP and have the appropriate Texas Department of Aging and Disability Services (DADS) licensure and/or certification.

All PCS providers must have a TPI and a National Provider Identifier (NPI).

Licensed and certified home health (LCHH) agencies that are currently enrolled through TMHP do not need to enroll as a CCP-PCS provider.

Providers that are currently contracted with DADS to administer consumer-directed services (CDS) or provide PCS through the service responsibility option (SRO), including providers currently enrolled in Texas Medicaid, are required to enroll/reenroll separately as a CDS or SRO provider. Texas Medicaid enrolls only new providers that are currently contracted with DADS to provide PCS through CDS and SRO.

Providers (other than those discussed above) that want to render PCS to Medicaid clients must enroll through TMHP. Texas Medicaid enrollment rules for PCS participation require providers to have one of the following categories of DADS licensure prior to enrollment:

• Personal Assistance Services (PAS)
• Licensed Home Health Services (LHHS)
• Licensed and Certified Home Health Services (LCHHS)
Additionally, providers must have a TPI in one of the following enrollment categories: LHHS agency, LCHHS agency, or PCS provider.

Providers that are enrolled as any entity other than a LHHS agency or LCHHS agency are required to meet the provider enrollment rules in order to participate in the delivery of PCS through Texas Medicaid.

Refer to: Subsection 3.2.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

3.8.2 Services/Benefits and Limitations

PCS is a benefit of CCP for Texas Medicaid clients who are birth through 20 years of age and who are not inpatients or residents of a hospital, in a nursing facility or ICF-MR, or in an institution for mental disease. PCS are support services provided to clients who meet the definition of medical necessity and require assistance with the performance of activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related functions due to a physical, cognitive, or behavioral limitation related to a client’s disability or chronic health condition. PCS are provided by someone other than the legal responsible adult of the client who is a minor child or the legal spouse of the client.

A responsible adult is an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.

PCS are those services that assist eligible clients in performing ADLs, IADLs, and other health-related functions. The scope of ADLs, IADLs, and health-related functions includes a range of activities that healthy, non-disabled adults can perform for themselves. Typically, developing children gradually and sequentially acquire the ability to perform these ADLs, IADLs, and health-related functions for themselves. If a typically developing child of the same chronological age could not safely and independently perform an ADL, IADL, or health-related function without adult supervision, then the client’s responsible adult ensures that the client’s needs for the ADLs, IADLs, and health-related functions are met.

PCS include direct intervention (assisting the client in performing a task) or indirect intervention (cueing the client to perform a task). ADLs, IADLs, and health-related functions include but are not limited to the following:

<table>
<thead>
<tr>
<th>ADLs</th>
<th>IADLs</th>
<th>Health-Related Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>Accessing and utilizing health services</td>
<td>Exercise</td>
</tr>
<tr>
<td>Dressing</td>
<td>Application/maintenance of prosthetics and orthotics</td>
<td>Medication administration and management</td>
</tr>
<tr>
<td>Eating</td>
<td>Communication</td>
<td>Range of motion</td>
</tr>
<tr>
<td>Grooming</td>
<td>Grocery/household shopping</td>
<td>Reporting as to the client’s condition, including changes to the client’s condition or needs and completing appropriate records</td>
</tr>
<tr>
<td>Maintaining continence</td>
<td>Light housework</td>
<td>Skin care — maintenance of the hygienic state of the client’s skin under optimal conditions of cleanliness and comfort</td>
</tr>
</tbody>
</table>

*Medical transportation includes the coordination of transportation to medical appointments and accompaniment to appointments. PCS does not include the payment for transportation or transportation vehicles since these services are available through the MTP.*
PCS do not include the following:

- ADLs, IADLs, or health-related functions that a typically developing child of the same chronological age could not safely and independently perform without adult supervision.
- Services that provide direct intervention when the client has the physical, behavioral, and cognitive abilities to perform an ADL, IADL, or health-related function without adult supervision.
- Services provided to an inpatient or a resident of a hospital, nursing facility, ICF-MR, or an institution for mental disease.
- Duplication of services provided by other programs.
- Services used for or intended to provide respite care or child care.

PCS is considered for reimbursement when providers use procedure code T1019 in conjunction with the appropriate modifier listed in the table below. PCS provided by a home health agency or PAS-only provider, including PCS being provided under the SRO defined in the 40 TAC Part 1, Chapter 41, must be billed in 15-minute increments. PCS provided by a consumer directed services agency (CDSA) under the consumer directed services (CDS) option defined in 40 TAC Part 1, Chapter 41, must submit the attendant fee in 15-minute increments. CDSAs must bill the administration fee once per calendar month per client for any month in which the client receives PCS under the CDS option and regardless of the number of PCS units of service the client receives under the CDS option during the month. PCS claims are considered for reimbursement only when TMHP has issued a valid PAN to a PCS provider.

<table>
<thead>
<tr>
<th>ADLs</th>
<th>IADLs</th>
<th>Health-Related Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
<td>Laundry</td>
<td>Use of DME</td>
</tr>
<tr>
<td>Positioning</td>
<td>Meal preparation</td>
<td></td>
</tr>
<tr>
<td>Transferring</td>
<td>Money management</td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td>Personal hygiene</td>
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</tr>
<tr>
<td></td>
<td>Medical transportation*</td>
<td></td>
</tr>
</tbody>
</table>

* Medical transportation includes the coordination of transportation to medical appointments and accompaniment to appointments. PCS does not include the payment for transportation or transportation vehicles since these services are available through the MTP.

When PCS is provided in a provider/client ratio other than one-to-one, only the time spent on direct PCS for each client may be billed. Total PCS billed for all clients cannot exceed the individual provider’s total number of hours spent at the POS.
Example: If the prior authorized PCS hours for Client A is 4 hours, Client B is 6 hours, and the actual time spent with both clients is 8 hours, the provider must bill for the actual one-on-one time spent with each client, not to exceed the client’s prior authorized hours or total hours worked. It would be acceptable to bill 4 hours for Client A and 4 hours for Client B, or 3 hours for Client A and 5 hours for Client B. It would not be acceptable to bill 5 hours for Client A and 3 hours for Client B. It would be acceptable to bill 10 hours if the individual person actually spent 10 hours onsite providing prior authorized PCS split as 4 hours for Client A and 6 hours for Client B. A total of 10 hours cannot be billed if the individual person worked only 8 hours.

3.8.2.1 Place of Services

PCS may be provided in the following settings if medically necessary:

- The client’s home
- The client’s school
- The client’s daycare facility
- Any community setting in which the client is located

Note: For claims filing purposes, the PCS provider must bill POS 2 (home) when submitting claims to TMHP.

Texas Medicaid does not reimburse providers for PCS that duplicate services that are the legal responsibility of school districts. The school district, through the School Health and Related Services (SHARS) program, is required to meet the client’s personal care needs while the client is at school. If those needs cannot be met by SHARS or the school district, the school district must submit documentation to the DSHS case manager indicating the school district is unable to provide all medically necessary services. When clients are receiving both PCS and PDN services from an individual person over the same span of time, the combined total number of hours for PCS and PDN are reimbursed according to the maximum allowable rate.

3.8.2.2 Client Eligibility

The PCS benefit is available to Texas Medicaid clients who:

- Are birth through 20 years of age.
- Are enrolled with Texas Medicaid.
- Are eligible for CCP.
- Have physical, cognitive, or behavioral limitations related to a disability or chronic health condition that inhibits the client’s ability to accomplish ADLs, IADLs, or health-related functions.

Personal care services include assistance with ADL’s and IADL’s, as hands-on assistance, cueing, redirecting, or intervening, to accomplish the ADL or IADL when one of the following criteria are met:

- The responsible adult’s need to sleep, work, attend school, and meet his/her own medical needs.
- The responsible adult’s legal obligation to care for, support, and meet the medical, educational, and psychosocial needs of his/her other dependents.
- The responsible adult’s physical ability to perform the PCS.

Clients who are enrolled in a DADS waiver program may also receive PCS if they are eligible for it, as long as the services that are provided through the waiver program and PCS are not duplicated. Clients who are enrolled in the following DADS waiver programs may access the PCS benefits if they meet the PCS eligibility requirements:

- Community Living Assistance and Support Services (CLASS)
- Deaf/Blind Multiple Disabilities (DBMD)
• Community-Based Alternatives (CBA)
• Consolidated Waiver Program (CWP)
• Medically Dependent Children Program (MDCP)
• Texas Home Living Waiver (TxHmL)
• Youth Empowerment Services (YES)
• Home and Community Services (HCS)

Note: **Clients who receive HCS Residential Support Services, Supervised Living Services, or Foster/Companion Care Services are not eligible to receive attendant care services from PCS.**

Clients must choose the program through which they receive attendant care, if they meet the eligibility requirements of both programs. Clients will be given the following options for the delivery of attendant care services:

- A client can receive all attendant care services through PCS.
- A client can decline PCS and receive all attendant care service through a waiver program, if the waiver program offers attendant care.

Clients who participate in the CDS option are required to choose one CDSA to provide services through PCS and the waiver program. CDSAs will only be permitted to file the financial management services (FMS) fee, also known as the monthly administrative fee, through one program. The CDSA should file the FMS claim through the program that provides the highest reimbursement rate.

Clients who are enrolled in STAR+PLUS receive the PCS benefit or personal attendant services through their STAR+PLUS health plan. Claims for these clients must be submitted to their STAR+PLUS health plans for payment consideration, not to TMHP. The STAR+PLUS health plans accept referrals and provide authorizations for eligible clients. The STAR+PLUS health plans process and reimburse personal attendant services claims for their clients who are 20 years of age or younger. DSHS does not assess or authorize PCS for STAR+PLUS-enrolled clients. TMHP does not process or authorize PCS for STAR+PLUS health plan clients.

TMHP processes and authorizes PCS for STAR waiver and PCCM clients.

**3.8.2.2.1 Accessing the PCS Benefit**

Clients must be referred to DSHS before receiving the PCS benefit. A referral can be made by any person who recognizes a client may have a need for PCS, including, but not limited to, the following:

- The client, a parent, a guardian, or a responsible adult
- A primary practitioner, primary care provider, or medical home
- A licensed health professional who has a therapeutic relationship with the client and ongoing clinical knowledge of the client
- A family member
- Home health, personal assistance, and consumer-directed service agency providers

Referrals to DSHS can be made to the appropriate DSHS Health Service Region, based on the client’s place of residence in the state. Clients, parents, or guardians may also call the TMHP PCS Client Line at 1-888-276-0702 for more information on PCS. PCS providers should provide the DSHS and/or TMHP PCS Client Contact Line contact information for the client or responsible adult.

Upon receiving a referral, DSHS assigns the client a case manager, who then conducts an assessment in the client’s home with the input and assistance of the client or responsible adult. Based on the assessment, the case manager identifies whether the client has a need for PCS. If the case manager...
identifies a need for PCS, the client or responsible adult is asked to select a Medicaid-enrolled PCS provider in their area. Client choices for PCS providers may include licensed home health agencies, consumer-directed services agencies (CDSAs), SRO providers, or PAS-only providers.

Once a provider is selected, the DSHS case manager prior authorizes a quantity of PCS based on the assessment and requests TMHP to issue a prior authorization number (PAN) to the selected PCS provider. The PCS provider uses the PAN to submit claims to TMHP for the services provided. DSHS also contacts the client’s primary practitioner (a licensed physician, APRN, or PA) or primary care provider to obtain a statement of need.

3.8.2.2 The Primary Practitioner’s Role in the PCS Benefit

A client accessing the PCS benefit must have a primary practitioner (a licensed physician, APRN, or PA) or a primary care provider who has a therapeutic relationship and ongoing clinical knowledge of the client. The primary practitioner or primary care provider must have established a diagnosis for the client and must provide continuing care and medical supervision of the client. When the DSHS case manager has determined the client has a need for the PCS benefit, the case manager contacts the client’s primary practitioner or primary care provider to obtain a Practitioner Statement of Need. The Statement of Need certifies the client has a physical, cognitive, or behavioral limitation related to a disability or chronic health condition and is birth through 20 years of age. The Statement of Need must be signed and dated by the primary practitioner or primary care provider within 60 days of the initial start of care (SOC). The primary practitioner or primary care provider must mail or fax the completed Statement of Need to the appropriate DSHS Health Services Region. DSHS keeps the signed and dated Statement of Need in the client’s case management record for the duration of the client’s participation in the benefit.

When a behavioral health condition exists, the primary practitioner may be a behavioral health provider. The primary practitioner must maintain the Practitioner Statement of Need in the client’s medical record. In addition, DSHS must maintain the Practitioner Statement of Need with the client’s PCAF and other forms related to the client’s case.

In the absence of primary practitioner medical record documentation and a Practitioner Statement of Need to support the client has a physical, cognitive or behavioral health condition impacting the client’s ability to perform an ADL and/or IADL PCS, payment may be recouped.

3.8.2.3 PCS Provided in Group Settings

PCS may be provided in a provider/client ratio other than one-to-one. PCS may be provided by more than one attendant to an individual client, or PCS may be provided to more than one client by one attendant. Settings in which providers can provide PCS in a provider/client ratio other than one-to-one include homes with more than one client needing PCS, foster homes, and independent living arrangements.

A PCS provider may provide PCS to more than one client over the span of the day as long as:

- Each client’s care is based on an individualized service plan.
- Each client’s needs and service plan do not overlap with another client’s needs and service plan.

3.8.3 Prior Authorization and Documentation Requirements

Prior authorization is required before services are provided. All PCS must be prior authorized by a DSHS case manager based upon client need, as determined by the client assessment. DSHS prior authorizes PCS for eligible clients, including clients enrolled in PCCM. The DSHS case manager notifies TMHP of the authorized quantity of PCS. TMHP sends a notification letter with the PAN to the client or responsible adult and the selected PCS provider if PCS is approved or modified. Only the client or responsible adult receives a notification letter with an explanation of denied services. PCS is prior authorized for 12-month periods. PCS providers must provide services from the start of care date agreed to by the client or responsible adult, the case manager, and the PCS provider.
A PCS provider may obtain prior authorization to provide enhanced PCS to clients with a behavioral health condition when the following criteria are met:

- The DSHS case manager completes the Personal Care Assessment Form (PCAF) and identifies the health condition.
- The PCAF indicates that the identified behavioral health condition impacts the client’s ability to perform an activity of daily living (ADL) and/or an instrumental activity of daily living (IADL).
- The PCAF indicates which ADL(s) and/or IADL(s) cannot be performed by the client without assistance.
- The DSHS case manager submits the appropriate modifier on the authorization request when the PCAF indicates that the performance of ADLs and/or IADLs are affected by the client’s behavioral health condition.

When a client experiences a change in condition, the client or responsible adult must notify the DSHS Health Service Office in the client’s region. A DSHS case manager must perform a new assessment and prior authorize any modifications in the quantity of PCS based on the new assessment. TMHP issues a new prior authorization and notifications are sent to the client or responsible adult and the selected PCS provider. If the change is made during a current 12-month prior authorization period, the new prior authorization for the revised services starts a new 12-month prior authorization period.

For continuing and ongoing PCS needs beyond the initial 12-month prior authorization period, a DSHS case manager must conduct a new assessment and submit a new authorization request to TMHP. TMHP sends a notification letter updating the prior authorization to the client, responsible adults, and the selected PCS provider.

Providers can call a toll-free PCS Provider Inquiry Line at 1-888-648-1517 for assistance with inquiries regarding the status of a PCS prior authorization. Providers should direct inquiries about other Medicaid services to the TMHP Contact Center at 1-800-925-9126. PCS providers should encourage the client or responsible adult to contact the appropriate DSHS Health Service Region with inquiries or concerns about the PCS assessment.

### 3.8.3.1 PCS Provider Responsibilities

PCS providers must comply with all applicable federal, state, and local laws and regulations.

All PCS providers must maintain written policies and procedures for obtaining consent for medical treatment in the absence of the responsible adult. The procedure and policy must meet the standards of the *Texas Family Code*.

Providers must accept clients only when there is a reasonable expectation the client’s needs can be adequately met in the POS. The POS must be able to support the client’s health and safety needs and adequately support the use, maintenance, and cleaning of all required medical devices, equipment, and supplies. Necessary primary and backup utility, communication, and fire safety systems must be available in the POS.

The PCS provider is responsible for the supervision of the PCS attendant as required by the PCS provider’s licensure requirements.

### 3.8.3.2 Documentation of Services Provided/Retrospective Review

Documentation elements are routinely assessed for compliance in retrospective review of client records, including the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client’s name and Medicaid identification number.
- All attendants’ arrival/departure times are documented with signature and time.
• Documentation of services correlates with and reflects medical necessity for the services provided on any given day.
• Client’s arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client.

3.8.4 Claims Information
TMHP processes PCS claims. PCS providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. Providers, other than home health agencies, enrolled as a PAS-only provider, a CDSA, or an SRO provider should file PCS claims using CMS-1500 paper claim form. Home health agencies, including those enrolled as a CDSA, or an SRO provider, should file PCS claims using the UB-04 CMS-1450 paper claim form. TMHP does not supply the forms.

Home health agencies and consumer-directed agencies that bill for PCS using procedure code T1019 must include the prior authorization number on claims submitted for reimbursement. Additionally, providers utilizing paper, TexMedConnect, or billing through EDI must include the prior authorization number with all claims submissions.

3.8.5 Reimbursement
Providers of PCS are reimbursed in accordance with 1 TAC §355.8441.

3.9 Private Duty Nursing (CCP)

3.9.1 Enrollment
LCHH services agencies may enroll to provide PDN under CCP. RNs and licensed vocational nurses (LVNs) may enroll independently to provide PDN under CCP.

Home health agencies must do all of the following:
• Comply with provider participation requirements for home health agencies that participate in Texas Medicaid
• Comply with mandatory reporting of suspected abuse and neglect of children or adults
• Maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the parent/guardian
• Comply with all requirements in this manual and the Texas Medicaid Bulletin

Independently-enrolled RNs and LVNs must be enrolled as providers in CCP and comply with all of the following:
• The terms of the Texas Medicaid Provider Agreement
• All state and federal regulations and rules relating to Texas Medicaid
• The requirements of this manual, including all updates and revisions published in the Texas Medicaid Bulletin, all handbooks, standards, and guidelines published by HHSC

Independently enrolled RNs and LVNs must also:
• Provide at least 30 days’ written notice to clients of their intent voluntarily to terminate services except in situations of potential threat to the nurse’s personal safety.
• Comply with mandatory reporting of suspected abuse and neglect of children.
• Maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the parent/guardian.
Independently enrolled RNs must:

- Hold a current license from the Texas BON or another compact state to practice as an RN.
- Agree to provide services in compliance with all applicable federal, state, and local laws and regulations, including the Texas Nursing Practice Act.
- Comply with accepted professional standards and principles of nursing practice.

Independently enrolled LVNs must:

- Hold a current license from the Texas BON to practice as an LVN.
- Agree to provide services in compliance with all applicable federal, state, and local laws and regulations, including the Texas Nursing Practice Act.
- Comply with accepted standards and principles of vocational nursing practice.
- Be supervised by an RN once per month. The supervision must occur when the LVN is present and be documented in the client’s medical record.

Refer to: Subsection 3.2.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.

### 3.9.2 Services/Benefits and Limitations

Medicaid clients who are birth through 20 years of age are entitled to all medically necessary private duty nursing (PDN) services and home health skilled nursing services.

PDN is nursing services, as described by the Texas Nursing Practice Act and its implementing regulations, for clients who meet medical necessity criteria listed below and who require individualized, continuous, skilled care beyond the level of skilled nursing visits provided under Texas Medicaid (Title XIX) Home Health Services skilled nursing (SN).

Nursing services are medically necessary under the following conditions:

- The requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations.
- The requested services correct or ameliorate the client’s disability, physical, mental illness, or condition. Nursing services correct or ameliorate the client’s disability, physical or mental illness, or condition when the services improve, maintain, or slow the deterioration of the client’s health status.
- There is no TPR financially responsible for the services.

Medically necessary nursing services may be either PDN services or home health skilled nursing services, depending on whether the client’s nursing needs can be met on a per-visit basis.

"Responsible adult" means an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the recipient. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.

PDN must be ordered or prescribed by a physician and provided by an RN, an LVN, or a licensed practical nurse (LPN).

Professional nursing provided by an RN, as defined in the Texas Nursing Practice Act, means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science,
as acquired by a completed course in an approved school of professional nursing. The term *does not* include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes.
- The maintenance of health or prevention of illness.
- The administration of a medication or treatment as ordered by a physician, podiatrist, or dentist.
- The supervision of delegated nursing tasks or teaching of nursing.
- The administration, supervision, and evaluation of nursing practices, policies, and procedures.
- The performance of an act delegated by a physician.
- Development of the nursing care plan.

Vocational nursing, as defined in the Texas *Nursing Practice Act*, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term *does not* include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual.
- Participating in the planning of the nursing care needs of an individual.
- Participating in the development and modification of the nursing care plan.
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual.
- Assisting in the evaluation of an individual’s response to a nursing intervention and the identification of an individual’s needs.
- Engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse’s experience, continuing education, and demonstrated competency.

Professional and vocational nursing care consists of those services that must, under state law, be performed by an RN or LVN as defined by the Texas *Nursing Practice Act §301.002*. These services include observation, assessment, intervention, evaluation, rehabilitation, care and counseling, and health teaching, and which are further defined as nursing services in 42 CFR §§409.32, 409.33, and 409.44.

- In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.
- The fact that the nursing care can be, or is, taught to the client or to the client’s family or friends does not negate the skilled aspect of the service when the service is performed by a nurse.
- If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a nursing service.
- If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the services cannot be regarded as nursing care.
- Some services are classified as nursing care on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if reasonable and necessary to the treatment
of the client’s illness or injury, would be covered on that basis. In some cases, however, the client’s condition may cause a service that would ordinarily not be considered nursing care to be considered nursing care. This would occur when the client’s condition is such that the service can be safely and effectively provided only by a nurse.

- A service that, by its nature, requires the skills of a nurse in order for it to be provided safely and effectively, continues to be a skilled service even if it is taught to the client, the client’s family, or other caregivers.

PDN should prevent prolonged and/or frequent hospitalizations or institutionalization and provide cost-effective and quality care in the most appropriate, least restrictive environment. PDN provides direct nursing care and caregiver training and education. The training and education is intended to optimize client health status and outcomes and to promote family-centered, community-based care as a component of an array of service options.

A request must include documentation from the provider to support the medical necessity of the service, equipment, or supply. CCP is obligated to authorize all medically necessary PDN to promote independence and support the client living at home.

PDN cannot be considered for the primary purpose of providing respite care, childcare, activities of daily living for the client, housekeeping services, or comprehensive case management beyond the service coordination required by the Texas Nursing Practice Act.

Claims for PDN services should be submitted to TMHP as follows:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1000 with modifier TD or TE</td>
<td>15 minutes</td>
</tr>
<tr>
<td>T1000</td>
<td>15 minutes</td>
</tr>
<tr>
<td>T1002</td>
<td>15 minutes</td>
</tr>
<tr>
<td>T1003</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

**Note:** Independently enrolled LVNs should use TE modifier, and independently enrolled RNs should use the TD modifier.

Home health agencies that provide PDN services for clients with a tracheostomy or clients who are ventilator-dependent receive additional reimbursement. Providers must bill using procedure codes T1000, T1002, or T1003 with UA modifier and one of the following diagnosis codes.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>51900 51901 51902 51909 V440 V550 V460 V4611 V4612 V4613</td>
</tr>
<tr>
<td>V4614 V468 V469</td>
</tr>
</tbody>
</table>

Because of the nature of the service being provided, some billing situations are unique to PDN. These billing requirements are as follows:

- All hours worked on one day should be billed together, on one detail, even if they involve two shifts. For example, if Nurse A works 7 a.m. to 11 a.m. and then returns and works 7 p.m. to 11 p.m., services should be billed for 8 hours (32 15-minute units) on one detail for that date of service.

- An individually enrolled nurse will not be reimbursed for more than 16 hours of PDN services in one day.
PDN may be delivered in a provider/client ratio other than one-on-one. An RN or LVN may provide PDN services to more than one client over the span of the day as long as each client’s care is based on an individualized POC, and each client’s needs and POC do not overlap with another client’s needs and POC. Only the time spent on direct PDN for each client is reimbursed. Total PDN billed for all clients cannot exceed an individual provider’s total number of hours at the POS.

A single nurse may be reimbursed for services to more than one client in a single setting when the following conditions are met:

- The hours for PDN for each client have been authorized through CCP.
- Only the actual “hands-on” time spent with each client is billed for that client.
- The hours billed for each client do not exceed the total hours approved for that client and do not exceed the actual number of hours for which services were provided.

**Example:** If the prior authorized PDN hours for Client A is 4 hours, Client B is 6 hours, and the actual time spent with both clients is 8 hours, the provider must bill for the actual one-on-one time spent with each client, not to exceed the client’s prior authorized hours or total hours worked. It would be acceptable to bill 4 hours for Client A and 4 hours for Client B, or 3 hours for Client A and 5 hours for Client B. It would not be acceptable to bill 5 hours for Client A and 3 hours for Client B. It would be acceptable to bill 10 hours if the nurse actually spent 10 hours onsite providing prior authorized PDN services split as 4 hours for Client A and 6 hours for Client B. A total of 10 hours cannot be billed if the nurse worked only 8 hours.

For reimbursement purposes, PDN should always be submitted with POS 2 (home) regardless of the setting in which services are actually provided. PDN may be provided in any of the following settings:

- Client’s home
- Client’s school
- Client’s daycare facility

PDN that duplicate services that are the legal responsibility of the school districts are not reimbursed. The school district, through the SHARS program, is required to meet the client’s skilled nursing needs while the client is at school; however, if those needs cannot be met by SHARS or the school district, documentation supporting medical necessity may be submitted to the CCP with documentation that nursing services are not provided in the school.

A responsible adult of a minor client or a client’s spouse may not be reimbursed for PDN even if the responsible adult is an enrolled provider or employed by an enrolled provider.

PDN is subject to retrospective review and possible recoupment when the medical record does not document that the provision of PDN is medically necessary based on the client’s situation and needs. The PDN provider’s record must explain all discrepancies between the service hours approved and the service hours provided. For example, the parents released the provider from all responsibility for the service hours or the agency was not able to staff the service hours. The release of provider responsibility does not indicate the client does not have a medical need for the services during those time periods.

**3.9.2.1 PDN Provided During a Skill Nursing Visit for TPN Administration Education**

For clients who receive PDN services and who also require TPN administration education, the intermittent SN visits may be reimbursed separately when the SN services are for client/caregiver training in TPN administration and the PDN provider is not an RN appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.

PDN and skilled nursing should not be routinely performed on the same date during the same time period.
PDN and skilled nursing will not be considered for reimbursement when the services are performed on the same date during the same time period without prior authorization approval.

If the skilled nursing visit for TPN education occurs during a time period when the PDN provider is caring for the client, both the PDN provider and the nurse educator must document in the client’s medical record the skilled services individually provided, including but not limited to:

- The start and stop time of each nursing providers specialized task(s)
- The client condition that requires the performance of skilled PDN tasks during the skilled nursing visit for TPN education
- The skilled services that each provided during that time period

Both the intermittent skilled nurse visit and the PDN services provided during the same time period may be recouped if the documentation does not support the medical necessity of each service provided.

### 3.9.2.2 Criteria

#### 3.9.2.2.1 Client Eligibility Criteria

To be eligible for PDN services, a client must meet all the following criteria:

- Be birth through 20 years of age and eligible for Medicaid and THSteps
- Meet medical necessity criteria for PDN
- Have a primary physician who:
  - Provides a prescription for PDN.
  - Establishes a POC.
  - Provides documentation to support the medical necessity of PDN services.
  - Provides continuing medical care and supervision of the client, including, but not limited to, examination or treatment within 30 days (initial requests of PDN services) or examination or treatment that complies with the THSteps periodicity schedule or is within 6 months of the PDN extension SOC date, whichever is more frequent (for extensions of PDN services). This requirement may be waived based on review of the client’s specific circumstances.
  - Provides specific written, dated orders for the client.
- Require care beyond the level of services provided under Texas Medicaid (Title XIX) Home Health Services

Clients who are birth through 17 years of age must reside with an responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

#### 3.9.2.2.2 Retroactive Client Eligibility

Retroactive eligibility occurs when an individual has been approved for Medicaid coverage but has not yet been assigned a Medicaid client number at the time of service delivery.

To be reimbursed for any current services after the client’s eligibility is on TMHP’s eligibility file, a provider must obtain prior authorization from CCP within 3 business days of the date eligibility is added to the TMHP system. This date is called the “add date.” The request must be received by CCP no later than 5 p.m., Central Time, on the third day to be considered received within 3 business days.

The provider is responsible for verifying eligibility. The provider is strongly recommended to access AIS or TMHP EDI frequently while providing services to the client. If services are discontinued before the client is added to TMHP’s eligibility file, the agency must still obtain prior authorization within 3 business days and submit all claims within 95 days from the add date.
3.9.2.2.3 Medical Necessity

PDN is considered medically necessary when a client has a disability, physical or mental illness, or chronic condition and requires continuous, skillful observations, judgments, and interventions to correct or ameliorate his or her health status.

Documentation submitted for a request for PDN must address the following questions:

- Is the client dependent on technology to sustain life.
- Does the client require ongoing and frequent skilled interventions to maintain or improve health status.
- Will delaying skilled intervention impact the health status of the client? If so, how will the health status be affected?
  - Deterioration of a chronic condition
  - Risk of death
  - Loss of function
  - Imminent risk to health status due to medical fragility

3.9.2.2.4 Place of Service (POS)

PDN is based on the need for skilled care in the client’s home; however, these services may follow the client and may be provided in accordance with 42 CFR §440.80.

The POS must be able to support the client’s health and safety needs. It must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client. Necessary primary and backup utilities, communication, fire, and safety systems must be available at all times.

3.9.2.2.5 Amount and Duration of PDN

The amount and duration of PDN should always be commensurate with the client’s medical needs. Requests for services should reflect changes in the client’s condition that affect the amount and duration of PDN.

3.9.3 Prior Authorization and Documentation Requirements

A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Requests for nursing services must be submitted on the required Medicaid authorization forms and include supporting documentation. The supporting documentation must:

- Clearly and consistently describe the client’s current diagnosis, functional status, and condition.
- Consistently describe the treatment throughout the documentation.
- Provide a sufficient explanation as to how the requested nursing services correct or ameliorate the client’s disability, physical or mental illness, or condition.

When a provider receives a referral for PDN, the provider must have an RN perform a nursing assessment of the client within the client’s home environment. This assessment must be performed before seeking prior authorization for PDN, with any request for PDN recertification, or any request to modify PDN hours.

The assessment must demonstrate the following:

- Medical necessity for PDN
- Safety of providing care in the proposed setting
• If birth through 17 years of age, the client resides with an responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

• “Responsible adult” means an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the recipient. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.

• An identified contingency plan is a structured process, designed by the responsible adult and the PDN provider, by which a client will receive care when a scheduled private duty nurse is unexpectedly unavailable, and the responsible adult is unavailable, or is not trained, to provide the nursing care. The identified responsible adult must be able to initiate the contingency plan.

• The existing level of care and any additional health-care services including the following: SHARS, MDCP, PT, OT, ST, primary home care (PHC), and case management services.

Note: Services provided under these programs do not prevent a client from obtaining all medically necessary services. Certain school services are provided to meet education needs, not medical needs. Records related to a client’s Individuals with Disabilities Education Act (IDEA) services are confidential records that clients do not have to release or provide access to.

When an RN completes a client assessment and identifies a medical necessity for ADLs or health-related functions to be provided by a nurse, the scope of PDN services may include these ADLs or health-related functions.

Note: CCP does not review or authorize PDN based on partial or incomplete documentation.

PDN must be prior authorized, and requests for PDN must be based on the current medical needs of the client.

The following criteria are considered for PDN prior authorization:

• The documentation submitted with the request is complete.

• The requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations.

• The explanation of the client’s medical needs is sufficient to support a determination that the requested services correct or ameliorate the client’s disability, physical or mental illness, or chronic condition.

• The client’s nursing needs cannot be met on an intermittent or part-time basis through Texas Medicaid (Title XIX) Home Health Services skilled nursing services.

• There is no TPR financially responsible for the services.

Only those services that CCP determines to meet the medical necessity criteria for PDN are reimbursed. Before CCP determines the requested nursing services do not meet the criteria, the TMHP medical director contacts the treating physician to determine whether additional information or clarification can be provided that would allow for the prior authorization of the requested PDN. If the TMHP medical director is not successful in contacting the treating physician or cannot obtain additional information or clarification, the TMHP medical director makes a decision based on the available information.

Providers must obtain prior authorization within 3 calendar days of the SOC for services that have not been prior authorized. During the prior authorization process, providers are required to deliver the requested services from the SOC date. The SOC date is the date agreed to by the physician, the PDN provider, and the client or responsible adult and is indicated on the submitted POC as the SOC date.

Note: CCP does not prior authorize an SOC date earlier than 7 calendar days before contact with TMHP.
Prior authorizations for more than 16 hours per day are not issued to a single, independently enrolled nurse. Requests for prior authorizations of PDN should always be commensurate with the client’s medical needs. Requests for services should reflect changes in the client’s condition that affect the amount and duration of PDN.

The length of the prior authorization is determined on an individual basis and is based on the goals and timelines identified by the physician, provider, and client or responsible adult. PDN is not prior authorized for more than 6 months at a time.

PDN is not prior authorized under any of the following conditions:

- The client does not meet medical necessity criteria.
- The client does not have a primary physician.
- The client is 21 years of age or older.
- The client’s needs are within the scope of services available through Texas Medicaid (Title XIX) Home Health Services SN and/or home health agency services because the needs can be met on a part-time or intermittent basis.

Intermittent skilled nursing visits for clients who receive private duty nursing (PDN) and who require TPN administration education may be considered for separate prior authorization if:

- The PDN provider is not an RN who has been appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.
- There is documentation that supports the medical need for an additional skilled nurse to perform TPN.

The skilled nursing services may be prior authorized only for the client/caregiver who will be trained in TPN administration.

### 3.9.3.1 Start of Care (SOC)

The SOC is the date that care is to begin, as agreed on by the family, the client’s physician, and the provider, and as listed on the POC and the CCP Prior Authorization Request Form. Providers are responsible for determining whether they can accept the client for services.

Once the provider accepts a client for service and accepts responsibility for providing PDN, the provider is required to deliver those services beginning with the SOC date. Providers are responsible for a safe transition of services when the authorization decision is a denial or a reduction of services. Providers are required to notify the physician and the client’s family on receipt of an authorization, a denial, or a change in PDN.

Providers must submit complete documentation no later than 3 business days from an SOC date to obtain initial coverage for the SOC date.

**Note:** Texas Medicaid (Title XIX) Home Health Services does not authorize a SOC date earlier than 3 business days before contact with TMHP.

For PDN recertification, CCP must receive complete documentation no later than 3 business days before the SOC date. It is recommended that recertification requests be submitted up to 30 days before the current authorization ends.

During the prior authorization process for initial and recertification requests, providers are required to deliver the requested services from the SOC date.

### 3.9.3.2 Prior Authorization of Initial Requests

Completed initial requests must be received and dated by CCP within 3 business days of the SOC. The request must be received by CCP no later than 5 p.m., Central Time, on the third day to be considered received within 3 business days. If a request is received more than 3 business days after the SOC, or after
5 p.m., Central Time, on the third day, authorization is given for dates of service beginning 3 business days before receipt of the completed request.

An initial PDN prior authorization request requires all of the following:

- CCP Prior Authorization Request form
- Home Health Plan of Care (POC) form
- CCP Nursing Addendum to Plan of Care form

All forms must be completed, signed, and dated by the primary physician within 30 calendar days prior to the SOC. The RN who completes the assessment and the client, or responsible adult must also sign the CCP Nursing Addendum to Plan of Care form.

The CCP Nursing Addendum to Plan of Care form must include all of the following:

- Updated problem list
- Updated rationale/summary page
- Contingency plan
- 24-hour daily care flowsheet
- Signed acknowledgement

Initial requests for PDN may be prior authorized for up to 90 days.

Refer to: Form CH.8, “Nursing Addendum to Plan of Care (CCP) (7 Pages)” in this handbook.


Form CH.7, “Home Health Plan of Care (POC)” in this handbook.

3.9.3.3 Authorization for Revision of Current Services

The provider may request a revision at any time during the authorization period if medically necessary. The provider must notify TMHP at any time during an authorization period if the client’s condition changes and the authorized services are not commensurate with the client’s medical needs.

Completed requests for revision of PDN hours during the current authorization period must be received by CCP within 3 business days of the revised SOC. The request must be received by CCP no later than 5 p.m., Central Time, on the seventh day to be considered received within 3 business days. If a request is received more than 3 business days after the revised SOC or after 5 p.m., Central Time, on the third day, authorization is given for dates of service beginning 3 business days before receipt of the completed request.

The revised PDN prior authorization request must include all of the following:

- CCP Prior Authorization Request form
- Home Health Plan of Care (POC) form
- CCP Nursing Addendum to Plan of Care form

The provider is responsible for ensuring that the physician reviews and signs the POC within 30 calendar days of the start date of the revised authorization period or more often if required by the client’s condition or agency licensure. The provider must maintain the physician-signed POC in the client’s medical record. PDN providers should not submit a revised POC unless they are requesting a revision.

Revision requests for PDN may be prior authorized up to 6 months.

If all necessary documentation is not submitted for a 6-month authorization, an authorization for a period up to 3 months may be approved.
Revisions to a current certification must fall within the certification period. If the revision extends beyond the current certification period, new authorization documentation must be submitted to CCP.

Refer to: Form CH.8, “Nursing Addendum to Plan of Care (CCP) (7 Pages)” in this handbook.
Form CH.7, “Home Health Plan of Care (POC)” in this handbook.

3.9.3.4 Recertifications of Authorizations

Completed extension requests must be received and dated by CCP at least 7 calendar days before, but no more than 30 days before, the current authorization expiration date. The request must be received by CCP no later than 5 p.m., Central Time, on the seventh day, to be considered received within 7 calendar days. If a request is received less than 7 calendar days before the current authorization expiration date, or after 5 p.m., Central Time, on the seventh day, authorization is given for dates of service beginning no sooner than 7 calendar days after the receipt of the completed request by CCP.

Recertifications may be prior authorized for up to 6 months. The following criteria are required for recertification authorization:

- The client has received PDN services for at least 3 months.
- No significant changes in the client’s condition have occurred for at least 3 months.
- No significant changes in the client’s condition are anticipated.
- The client’s responsible adult, physician, and provider agree that a recertification authorization is appropriate.

The recertification process includes the following:

- All required documentation for PDN services (including the Physician POC, the Nursing Addendum to POC, and the CCP Prior Authorization Request Form)
- CCP Private Duty Nursing 6-Month Authorization form, which must be signed and dated by the primary physician, nurse provider, and client, or responsible adult

The nursing care provider is responsible for ensuring that a new Physician POC is obtained within 30 calendar days of the authorization period ending and maintained in the client’s record. Providers should not submit interim POCs to CCP unless requesting a revision.

The nursing care provider should notify CCP at any time during the authorization period if the client’s condition and need for skilled nursing care significantly changes.

The nursing care provider may request a revision from TMHP at any time during the authorization period if the client’s condition requires it.

All authorization timelines apply to recertifications also.

Refer to: Form CH.8, “Nursing Addendum to Plan of Care (CCP) (7 Pages)” in this handbook.
Form CH.7, “Home Health Plan of Care (POC)” in this handbook.

3.9.3.5 Termination of Authorization

An authorization may be terminated when:

- Client is no longer eligible for CCP or Medicaid.
- Client no longer meets the medical necessity criteria for PDN.
• POS can no longer accommodate the client’s health and safety.
• Client or responsible adult refuses to comply with the service plan and compliance is necessary to ensure the client’s health and safety.

3.9.3.6 Client/Provider Notification

When PDN is approved as requested, the provider receives written notification. The provider is responsible for notifying the client/family and the physician of the authorized services.

CCP notifies the client and provider in writing when the following instances occur:

• PDN is denied.
• PDN hours authorized are less than the hours requested on the POC.
• PDN hours are modified (e.g., hours are requested by the week but are authorized by the day).
• CCP receives incomplete information from the provider.
• Dates of service authorized are different from those requested.
• The provider is responsible for notification and coordination with the physician and family.

3.9.3.7 Authorization Appeals

Providers may appeal denials or modifications of requested PDN with documentation to support the medical necessity of the requested PDN. A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. Appeals must be submitted to CCP with complete documentation and any additional information within 2 weeks of the date on the decision letter. If changes are made to the authorization based on this documentation, CCP goes back no more than 3 business days for initial or revision requests and no more than 7 calendar days for recertification requests when additional documentation is submitted.

The client or responsible adult is notified of any denial or modification of requested services and is given information about how to appeal CCP’s decision.

Documentation forms have been designed to improve communication between providers and CCP. The forms are available in English and Spanish.

All documentation must be submitted together, and requests are not reviewed until all documentation is received. If complete documentation is received at CCP by 3 p.m., Central Time, a response is returned to the provider within 1 business day. Complete documentation for initial, revision, recertification, and extension requests for PDN authorizations include all of the following:

• Form CH.1, “CCP Prior Authorization Request Form” in this handbook
• Form CH.7, “Home Health Plan of Care (POC)” in this handbook.
• Form CH.8, “Nursing Addendum to Plan of Care (CCP) (7 Pages)” in this handbook

3.9.3.8 CCP Prior Authorization Request Form

The CCP Prior Authorization Request Form must be completed, signed, and dated by the physician. The physician must mark the Private Duty Nursing box documenting the stability of the client for PDN. All requested dates of service must be included.

3.9.3.9 Home Health Plan of Care (POC)

The POC must be recommended, signed, and dated by the client’s primary physician. A POC must meet the standards outlined in the 42 CFR §484.18 related to the written POC. The primary physician must review and revise the POC, in consultation with the provider and the responsible adult, for each prior authorization, or more frequently as the physician deems necessary or the client’s situation changes.
Pursuant to 42 CFR §484.18, the POC must include the following elements:

- All pertinent diagnoses
- Client’s mental status
- Types of services requested including amount, duration, and frequency
- Medical equipment needed
- Prognosis
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- Medications, including dose, route, and frequency
- Treatments, including amount, duration, and frequency
- Safety measures needed
- Instructions for a timely discharge from service, if appropriate
- Date the client was last seen by the physician
- Other medical orders
- Start- and end-of-care dates
- Responsible adult and/or identified contingency plan

**Note:** Coverage periods do not coincide necessarily with calendar weeks or months but, instead, cover a number of services to be scheduled between a start and end date that is assigned during the prior authorization period. A week includes the day of the week on which the prior authorization period begins and continues for 7 days. For example, if the prior authorization starts on a Thursday, the prior authorization week runs Thursday through Wednesday. The number of nursing hours authorized for a week must be contained in that prior authorization week. Hours billed in excess of those authorized for the PAN week are subject to recoupment.

### 3.9.3.10 Nursing Addendum to Plan of Care (CCP) Form

The Nursing Addendum to Plan of Care (CCP) Form addresses PDN eligibility criteria, nursing care plan summary, health history summary, 24-hour schedule, and the rationale for the hours of PDN requested.

The following is a description of the nursing care plan summary:

- The nursing care summary is not a complete nursing care plan.
- Information must be client-focused and detailed.
- The Problem List must reflect the reasons that nursing services are needed. The problem list is not the nursing care plan. Providers should identify two-to-four current priority problems from their nursing care plan. The problem does not need to be stated as a nursing diagnosis. The problems listed should focus on the primary reasons that a licensed nurse is required to care for the client. Other attached documents are not accepted in lieu of this section.
- The Goals should relate directly to the problems listed and be client-specific and measurable. Goals may be short- or long-term; however, for many clients who receive PDN, the goals generally are long-term.
• The Outcomes are the effects of the provider’s nursing interventions and must be measurable. Generally, these are more short-term than goals. For initial requests, list expected outcomes. Extension requests should note the results of nursing interventions.

• The Progress should be viewed as a “yardstick” or continuum on which progress toward goals is marked. Initial requests should state expected progress for the authorization period. Extension requests should list the progress noted during the previous authorization period. It is recognized that all progress may not be positive.

• The addendum must summarize the client’s health problems relating to the medical necessity for PDN.

• The addendum must clearly communicate a picture of the client’s overall condition and nursing care needs.

• The summary of recent health history is imperative in determining whether the client’s condition is stable or if new nursing care needs have been identified. This section gives the PDN provider an opportunity to describe the client’s recent health problems, including acute episodes of illness, hospitalizations, injuries, etc. The summary should create a complete picture of the client’s condition and nursing care needs. The summary may cover the previous 90 days, even though the authorization period is 60 days; however, the objective of the summary is to capture the client’s recent health problems and current health priorities. This section should not be merely a list of events. This section is the place to indicate the frequency of nursing interventions if they are different from the physician’s order on the POC, such as, the order may be for a procedure to be PRN (Pro Re Nata—“As Needed”), but it is actually being performed every 2 hours.

• The addendum must include the rationale for increasing, decreasing, or maintaining the level of PDN and must relate to the client’s health problems and goals.

• The addendum must include the provider’s plan to decrease hours or discharge from service (if appropriate).

3.9.3.10.1 The Client’s 24-Hour Daily Schedule

All direct-care services must be identified. It is understood that the schedule may change, as the client’s needs change. CCP does not have to be notified of changes in the schedule except as they occur when a PDN recertification is requested.

3.9.3.11 Responsible Adult or Identified Contingency Plan Requirement

For clients who are birth through 17 years of age, the client must reside with an identified responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

- “Responsible adult” means an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the recipient. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.

- An identified contingency plan is a structured process, designed by the responsible adult and the PDN provider, by which a client will receive care when a scheduled private duty nurse is unexpectedly unavailable, and the responsible adult is unavailable, or is not trained, to provide the nursing care. The responsible adult must be able to initiate the identified contingency plan.

The responsible adult’s signature must be on the form acknowledging:

- Information about CCP PDN has been discussed and received.

- PDN may change or end based on a client’s need for nursing care.
• PDN is not authorized for the primary purpose of providing respite, childcare, ADLs, or housekeeping.

• All requirements have been met before seeking prior authorization for PDN.

• The responsible adult has participated in the development of the POC and the nursing care plan for the client.

• Emergency plans have been made and are part of the client's care plan.

• The client or responsible adult agrees to follow the physician's POC.

3.9.3.12 Documentation of Services Provided/Retrospective Review

Documentation elements that are routinely assessed for compliance in retrospective review of client records include, but are not limited to, the required documentation noted above, as well as the following:

• All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.

• Each page of the record documents the client’s name and Medicaid identification number.

• Client assessment time is documented at the beginning of each shift.

• All nurses' arrival/departure times are documented with signature and time in the narrative section of the nurses' notes.

• Entries are dated and timed every 1 to 2 hours.

• The name of the medication, dose, route, time given, client response, and other pertinent information is recorded when medication is administered.

• The name of treatment, time given, route or method used, client response, and other pertinent information is provided when treatments are administered.

• The amount, type, times given, route or method used, client response, and other pertinent information is provided when feedings are administered.

• The POC and documentation of services correlate with and reflect medical necessity for the services provided on any given day.

• A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

• Client's arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client.

• Documentation of teaching the client or the client's responsible adult includes the length of time, the subject of the teaching, the understanding of the subject matter by the person receiving the teaching, and other pertinent information.

• Supervisory visits include specifics of the visit.

• If a client is receiving skilled nursing services through another program or service in addition to CCP, such as MDCP, each provider’s shift notes designate specifically which type of service they are providing during that shift.

3.9.4 Claims Information

PDN providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. Home health agencies must submit claims on the UB-04 CMS-1450 paper claim form. Independently enrolled nurses must submit claims on the CMS-1500 paper claim form. TMHP does not supply the forms.
Refer to: Section 3, TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6, Claims Filing (Vol. 1, General Information) for general information about claims filing.


3.9.5 Reimbursement
PDN services are reimbursed in accordance with 1 TAC §355.8441.

3.10 Therapy Services (CCP)
Physical (PT), occupational (OT), and speech therapy (ST) services beyond the limitations of Texas Medicaid and Title XIX Home Health Services are benefits of the CCP for clients birth through 20 years of age who are CCP eligible when:

- Therapy is prescribed by a licensed therapist.
- Documentation of medical necessity supports a condition that requires ongoing therapy or rehabilitation in the usual course, treatment, and management of the client’s condition.
- Therapy services are provided by a licensed therapist.
- Therapy is provided in one of the following places of service:
  - CORF/ORF
  - Freestanding rehabilitation facility
  - Home
  - Licensed hospital
  - Medicaid-enrolled private therapist office
  - Physician office

This section does not apply to CORFs/ORFs.

Refer to: Subsection 3.4, “Comprehensive Outpatient Rehabilitation Facilities (CORFs)/ Outpatient Rehabilitation Facilities (ORFs)” in this handbook.

Subsection 3.12, “Inpatient Rehabilitation Hospital (Freestanding) (CCP)” in this handbook.

Therapy may be performed by auxiliary personnel (physical therapist, occupational therapist, speech-language pathologist assistants) under the supervision of the physician or the licensed independently practicing therapist.

PT, OT, and ST may be performed in the office or home setting and may be authorized to be provided in the following locations: home of the client, home of the caregiver/guardian, client’s daycare facility, or the client’s school.

Services provided to a client on school premises are only permitted when delivered before or after school hours. The only CCP therapy that can be delivered in the client’s school during regular school hours are those delivered by school districts as School Health and Related Services (SHARS) in POS 9.

Refer to: Section 4, “School Health and Related Services (SHARS)” in this handbook for more information regarding SHARS.
PT provided in the nursing home setting is limited to the nursing facility because it must be available to nursing home residents on an “as needed” basis and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside-qualified resources. Nursing home facilities should refrain from admitting clients who need goal directed therapy if the facility is unable to provide these services.

Home health agencies that perform therapy services under CCP are allowed one visit per day per therapy type and paid at the Statewide visit rate.

Services That Are Not a Benefit

The following services are not a benefit of CCP.

- Procedure code 97010 (application of a modality to one or more areas; hot or cold packs).
- Services that are not medically necessary. Examples include, but are not limited to:
  - Massage therapy that is the sole therapy or is not part of a therapeutic plan of care (POC) to address an acute condition
  - Hippotherapy
  - Separate reimbursement for VitalStim therapy for dysphagia
  - Treatment solely for the instruction of other agency or professional personnel in the client’s physical, occupational, or speech therapy program
  - Training in nonessential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling)
  - Emotional support, adjustment to extended hospitalization and/or disability, and behavioral readjustment
  - Therapy prescribed primarily as an adjunct to psychotherapy

3.10.1 Occupational Therapy (OT)

3.10.1.1 Enrollment

HHSC allows enrollment of independently-practicing licensed occupational therapist under CCP. The information in this section applies to CCP services only.

3.10.1.2 Services/Benefits and Limitations

A procedural modifier is required when submitting claims for OT services. Providers must use modifier GO for OT services. Procedural modifiers are not required for evaluations and reevaluations.

Evaluations (procedure code 97003) are limited to once every 180 days any provider. Reevaluations (procedure code 97004) are limited once per 30 days, any provider.

An evaluation or reevaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

If a therapy evaluation or reevaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or reevaluation will be denied. Physical therapy evaluation (procedure code 97003) or reevaluation (procedure code 97004) will be denied as part of the following occupational therapy procedure codes billed with Modifier GO.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>97012</td>
</tr>
<tr>
<td>97034</td>
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<tr>
<td>97140</td>
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</tbody>
</table>
The following procedure codes are billed in 15-minute increments:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>97799</td>
<td>97799</td>
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</tbody>
</table>

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to 2 hours (4 units) per day individual, group, or a combination of individual and group therapy, per therapy type. Each 15 minutes equals one unit.

All 15-minute increment procedure codes are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not evenly divisible by 15, minutes greater than 7 are converted to 1 unit and 7 or fewer minutes are converted to 0 unit.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to 1 unit. Consequently, 68 total billable minutes = 5 units of service. The following table indicates the time intervals for 0 through 8 units:

<table>
<thead>
<tr>
<th>Units</th>
<th>Number of Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 units</td>
<td>0 minutes through 7 minutes</td>
</tr>
<tr>
<td>1 unit</td>
<td>8 minutes through 22 minutes</td>
</tr>
<tr>
<td>2 units</td>
<td>23 minutes through 37 minutes</td>
</tr>
<tr>
<td>3 units</td>
<td>38 minutes through 52 minutes</td>
</tr>
<tr>
<td>4 units</td>
<td>53 minutes through 67 minutes</td>
</tr>
<tr>
<td>5 units</td>
<td>68 minutes through 82 minutes</td>
</tr>
<tr>
<td>6 units</td>
<td>83 minutes through 97 minutes</td>
</tr>
<tr>
<td>7 units</td>
<td>98 minutes through 112 minutes</td>
</tr>
<tr>
<td>8 units</td>
<td>113 minutes through 127 minutes</td>
</tr>
</tbody>
</table>

The following procedure codes are limited to once per day, for each therapy type (PT and OT):

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>97012</td>
<td>97014</td>
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<tr>
<td>97016</td>
<td>97018</td>
</tr>
<tr>
<td>97022</td>
<td>97024</td>
</tr>
<tr>
<td>97026</td>
<td>97028</td>
</tr>
<tr>
<td>97150</td>
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</tbody>
</table>

If procedure code 97750 is billed with an office visit on the same date of service by the same provider, the office visit will be denied.

Procedure code 97150 will be denied if billed on the same date of service by the same provider as procedure code 97750.

Electrical stimulation therapy (procedure code 97032) may be considered with documentation of medical necessity.
Prior authorization is required for occupational therapy except for therapy provided in the inpatient setting, evaluations or re-evaluations, services provided through the school Health and Related Services (SHARS) or Early Childhood Intervention (ECI) programs.

Refer to: Section 4, “School Health and Related Services (SHARS)” in this handbook for more information regarding SHARS.

Note: It is not mandatory for ECI programs to request prior authorization for reimbursement of therapy services; however, in order to expedite claims processing providers should submit the ECI Request for Initial/Renewal Outpatient Therapy form with their claim form. All therapists involved with the client must sign and date the ECI Request for Initial/Renewal Outpatient Therapy form. When a physician does not sign the therapy form, a copy of a separate prescription for therapies must be included with the physician’s original signature, and must be dated on or before the actual beginning date of the therapy. A physician’s prescription is required every 180 days.

The following documentation must be submitted to TMHP prior to the start of care for the current episode of therapy for consideration for prior authorization:

- A current written order by a physician and based on medical necessity.
- A prescription is considered current when it is signed and dated on or no later than 60 days before the start of therapy.
- A ”Request for Initial Outpatient Therapy (Form TP-1)” or ”Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)” must be submitted to TMHP prior to the start of care for the current episode of therapy.
- The most recent evaluation and treatment plan. To establish medical necessity, the written treatment plan must include the following:
  - The age of the client at the time of evaluation
  - Diagnosis
  - Description of specific therapy being prescribed
  - Specific treatment goals related to the client’s individual needs. Therapy goals may include improving function, maintenance of function or slowing of the deterioration of function.
- For an initial request, anticipated measurable progress toward goals, the prognosis, and the client’s gross motor skills in years or months.
- For a new request for additional therapy, documentation of all progress made from the beginning of the previous treatment period.
- Duration and frequency of therapy
- Requested dated of service

Typical sessions do not exceed 1 hour in length. When sessions must exceed 1 hour, documentation supporting the need for longer sessions is required. There is no limit on the number of sessions that may be provided but the number of sessions per week must be supported by documentation showing that such sessions are medically necessary.

A request for OT services may be prior authorized for no longer than 180 days duration. A new request must be submitted if therapy is required for a longer duration.

The GO modifier is required on all prior authorization requests for physical, occupational, and speech therapy.
When requesting prior authorization for group occupational therapy, the provider must submit documentation supporting the group process as being medically necessary and beneficial to the child. When group therapy is authorized, weekly therapy limits will not be exceeded.

If a provider discontinues therapy with a client and a new provider begins therapy during an existing authorization period, submission of a new plan of care and documentation of the last therapy visit with the previous provider is required along with a letter from the client, or responsible adult stating the date therapy ended with the previous provider.

### 3.10.1.4 Claims Information

Providers must submit claims for therapy services in an approved electronic claims format, a CMS-1500, or UB-04 CMS-1450 claim form from the vendor of their choice. TMHP does not supply the forms.

Providers can refer to Volume 1 for general information regarding claims filing.

Refer to:
- Section 3, TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.
- Section 6, Claims Filing (Vol. 1, General Information) for general information about claims filing.

### 3.10.1.5 Reimbursement

OT services are reimbursed in accordance with 1 TAC §355.8441.

See the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

### 3.10.2 Physical Therapy (PT)

#### 3.10.2.1 Enrollment

HHSC allows enrollment of independently-practicing licensed physical therapist under CCP. The information in this section applies to CCP services only.

#### 3.10.2.2 Services/Benefits and Limitations

A procedural modifier is required when submitting claims for PT services. Providers must use modifier GP for PT services. Procedural modifiers are not required for evaluations and reevaluations.

Evaluations (procedure code 97001) are limited to once every 180 days any provider. Reevaluations (procedure code 97002) are limited once per 30 days, any provider.

An evaluation or reevaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

If a therapy evaluation or reevaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or reevaluation will be denied. Physical therapy evaluation (procedure code 97001) or reevaluation (procedure code 97002) will be denied as part of the following physical therapy procedure codes billed with Modifier GP.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>97012</td>
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<tr>
<td>97034</td>
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<tr>
<td>97140</td>
</tr>
</tbody>
</table>
The following procedure codes are billed in 15-minute increments:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97799</td>
</tr>
</tbody>
</table>

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to 2 hours (4 units) per day individual, group, or a combination of individual and group therapy, per therapy type. (2 hrs of PT and 2 hrs of OT) Each 15 minutes equals one unit.

All 15-minute increment procedure codes are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not evenly divisible by 15, minutes greater than 7 are converted to 1 unit and 7 or fewer minutes are converted to 0 unit.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to 1 unit. Consequently, 68 total billable minutes = 5 units of service.

Refer to: Subsection 3.10.1, “Occupational Therapy (OT)” in this handbook for 15-minute conversion table.

The following procedure codes are limited to once per day, for each therapy type (PT and OT):

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>97032</td>
</tr>
<tr>
<td>97124</td>
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<tr>
<td>97762</td>
</tr>
</tbody>
</table>

If procedure code 97750 is billed with an office visit on the same date of service by the same provider, the office visit will be denied.

Procedure code 97150 will be denied if billed on the same date of service by the same provider as procedure code 97750.

Electrical stimulation therapy (procedure code 97032) may be considered with documentation of medical necessity.

### 3.10.2.3 Prior Authorization and Documentation Requirements

Prior authorization is required for physical therapy except for therapy provided in the inpatient setting, evaluations or re-evaluations, services provided through the school Health and Related Services (SHARS) or Early Childhood Intervention (ECI) programs.

Refer to: Section 4, “School Health and Related Services (SHARS)” in this handbook for more information regarding SHARS.

Note: It is not mandatory for ECI programs to request prior authorization for reimbursement of therapy services; however, in order to expedite claims processing providers should submit the ECI Request for Initial/Renewal Outpatient Therapy form with their claim form. All therapists involved with the client must sign and date the ECI Request for Initial/Renewal Outpatient Therapy form. When a physician does not sign the therapy form, a copy of a
separate prescription for therapies must be included with the physician’s original signature, and must be dated on or before the actual beginning date of the therapy. A physician’s prescription is required every 180 days.

The following documentation must be submitted to TMHP prior to the start of care for the current episode of therapy for consideration for prior authorization:

- A current written order by a physician and based on medical necessity.
- A prescription is considered current when it is signed and dated on or no later than 60 days before the start of therapy.
- A “Request for Initial Outpatient Therapy (Form TP-1)” or “Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)” must be submitted to TMHP prior to the start of care for the current episode of therapy.
- The most recent evaluation and treatment plan. To establish medical necessity, the written treatment plan must include the following:
  - The age of the client at the time of evaluation
  - Diagnosis
  - Description of specific therapy being prescribed
  - Specific treatment goals related to the client’s individual needs. Therapy goals may include improving function, maintenance of function or slowing of the deterioration of function.
  - For an initial request, anticipated measurable progress toward goals, the prognosis, and the client’s gross motor skills in years or months.
  - For a new request for additional therapy, documentation of all progress made from the beginning of the previous treatment period.
  - Duration and frequency of therapy
  - Requested dated of service

Typical sessions do not exceed 1 hour in length. When sessions must exceed 1 hour, documentation supporting the need for longer sessions is required. There is no limit on the number of sessions that may be provided but the number of sessions per week must be supported by documentation showing that such sessions are medically necessary.

A request for PT services may be prior authorized for no longer than 180 days duration. A new request must be submitted if therapy is required for a longer duration.

The GP modifier is required on all prior authorization requests for physical therapy.

When requesting prior authorization for group physical therapy, the provider must submit documentation supporting the group process as being medically necessary and beneficial to the child. When group therapy is authorized, weekly therapy limits will not be exceeded.

If a provider discontinues therapy with a client a new provider begins therapy during an existing authorization period, submission of a new plan of care and documentation of the last therapy visit with the previous provider is required along with a letter from the client, or responsible adult stating the date therapy ended with the previous provider.

3.10.2.4 Claims Information

Providers must submit claims for therapy services in an approved electronic claims format, a CMS-1500, or UB-04 CMS-1450 claim form from the vendor of their choice. TMHP does not supply the forms.

Providers may refer to Volume 1 for general information regarding claims filing.
Refer to: Section 3, TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6, Claims Filing (Vol. 1, General Information) for general information about claims filing.


3.10.2.5 Reimbursement
PT services are reimbursed in accordance with 1 TAC §355.8441.

See the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

3.10.3 Speech Therapy (ST)

3.10.3.1 Enrollment
HHSC allows enrollment of independently-practicing licensed SLPs under CCP. The information in this section applies to CCP services only.

3.10.3.2 Services/Benefits and Limitations
A procedural modifier is required when submitting claims for ST services. Providers must use modifier GN for ST services. Procedural modifiers are not required for evaluations and reevaluations.

Speech therapy evaluation (procedure code 92506) is limited to once every 180 days, any provider.

Speech therapy reevaluations (procedure code S9152) is limited to once every 30 days, any provider.

Speech therapy treatment codes 92507, 92508, and 92526 are payable in 15-minute increments at a maximum of four units (one hour) per day.

Speech therapy evaluation and reevaluations will be denied when billed on the same date of service, any provider as procedure codes 92507 and 92508 with modifier GN.

If a provider is requesting group speech therapy, the provider must submit documentation supporting the group process as being medically necessary and beneficial to the child. When group therapy is authorized, weekly therapy limits will not be exceeded.

Procedure codes 92630 and 92633 are limited to 2 procedures per day, for different procedures, billed by the same provider or provider group.

Procedure codes 92526 and 92610 may be considered for reimbursement for evaluation and treatment of swallowing dysfunctions and oral functions for feeding. Procedure code 97535 is used for speech therapy services for training for augmentative communication devices.

Procedure code 97535 is used for speech therapy services for training for augmentative communication devices.

3.10.3.3 Prior Authorization and Documentation Requirements
Prior authorization is required for speech therapy except for therapy provided in the inpatient setting, evaluations or re-evaluations, services provided through the school Health and Related Services (SHARS) or Early Childhood Intervention (ECI) programs.
Refer to: Section 4, “School Health and Related Services (SHARS)” in this handbook for more information regarding SHARS.

Note: It is not mandatory for ECI programs to request prior authorization for reimbursement of therapy services; however, in order to expedite claims processing providers should submit the ECI Request for Initial/Renewal Outpatient Therapy form with their claim form. All therapists involved with the client must sign and date the ECI Request for Initial/Renewal Outpatient Therapy form. When a physician does not sign the therapy form, a copy of a separate prescription for therapies must be included with the physician’s original signature, and must be dated on or before the actual beginning date of the therapy. A physician’s prescription is required every 180 days.

The following documentation must be submitted to TMHP prior to the start of care for the current episode of therapy for consideration for prior authorization:

- A current written order by a physician and based on medical necessity.
- A prescription is considered current when it is signed and dated on or no later than 60 days before the start of therapy.
- A “Request for Initial Outpatient Therapy (Form TP-1)” or “Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)” must be submitted to TMHP prior to the start of care for the current episode of therapy.
- The most recent evaluation and treatment plan. To establish medical necessity, the written treatment plan must include the following:
  - The age of the client at the time of evaluation
  - Diagnosis
  - Description of specific therapy being prescribed
  - Specific treatment goals related to the client’s individual needs. Therapy goals may include improving function, maintenance of function or slowing of the deterioration of function.
  - For an initial request, anticipated measurable progress toward goals, the prognosis, and the client’s gross motor skills in years or months.
  - For a new request for additional therapy, documentation of all progress made from the beginning of the previous treatment period.
  - Duration and frequency of therapy
  - Requested dated of service

Typical sessions do not exceed 1 hour in length. When sessions must exceed 1 hour, documentation supporting the need for longer sessions is required. There is no limit on the number of sessions that may be provided but the number of sessions per week must be supported by documentation showing that such sessions are medically necessary.

A request for ST services may be prior authorized for no longer than 180 days duration. A new request must be submitted if therapy is required for a longer duration.

The GN modifier is required on all prior authorization requests for physical, occupational, and speech therapy.

If a provider discontinues therapy with a client a new provider begins therapy during an existing authorization period, submission of a new plan of care and documentation of the last therapy visit with the previous provider is required along with a letter from the client, or responsible adult stating the date therapy ended with the previous provider.
3.10.3.4 Claims Information

Providers must submit claims for therapy services in an approved electronic claims format, a CMS-1500, or UB-04 CMS-1450 claim form from the vendor of their choice. TMHP does not supply the forms.

Providers may refer to Volume 1 for general information regarding claims filing.

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

Section 6, Claims Filing (Vol. 1, General Information) for general information about claims filing.


3.10.3.5 Reimbursement

ST services are reimbursed in accordance with 1 TAC §355.8441.

See the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

3.11 Inpatient Psychiatric Hospital/Facility (Freestanding) (CCP)

3.11.1 Enrollment

To be eligible to participate in CCP, a psychiatric hospital/facility must be accredited by the Joint Commission, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Facilities certified by Medicare must also meet the Joint Commission accreditation requirements.

Freestanding psychiatric hospitals enrolled in Medicare may also receive payment for Medicare deductible and coinsurance amounts with the exception of clients 21 through 64 years of age. The information in this section is applicable to CCP services only.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA are not reimbursed for laboratory services.

3.11.1.1 Continuity of Hospital Eligibility Through Change of Ownership

Under procedures set forth by the CMS, Department of Health and Human Services, a change in ownership of a hospital does not terminate Medicare eligibility. Medicaid participation may be continued subject to the following requirements:

- Recertification as a Title XVIII (Medicare) hospital is obtained if applicable.
- A new Title XIX (Medicaid) agreement between the hospital and HHSC under new ownership is obtained.

Providers can obtain the Medicaid hospital participation agreement by contacting TMHP Provider Enrollment.

Refer to: Subsection 3.2.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.

Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in Radiology, Laboratory and Physiological Lab Services Handbook (Vol. 2, Provider Handbooks) for information about CLIA requirements.
3.11.2 Services/Benefits and Limitations

**Note:** Outpatient services for hospital-based psychiatric day treatment programs or psychiatric facilities are not a benefit of Texas Medicaid.

Inpatient psychiatric treatment in a nationally accredited freestanding psychiatric facility or a nationally accredited state psychiatric hospital is a benefit of Texas Medicaid for clients birth through 20 years of age at the time of the service request and service delivery if:

- The client has a psychiatric condition that requires inpatient treatment.
- The inpatient treatment is directed by a psychiatrist.
- The inpatient treatment is provided in a nationally accredited facility or hospital.
- The provider is enrolled in Texas Medicaid.

Admissions must be medically necessary except for court ordered services for mental health commitments or a condition of probation and are subject to Texas Medicaid’s retrospective utilization review (UR) requirements.

When a client requires admission or once the client becomes Medicaid eligible while in the facility, a certification of need must be completed and placed in the client's medical record within 14 days of the admission.

Client services must be provided in the most appropriate setting and in a timely manner to meet the mental health needs of the client.

Inpatient admissions for the single diagnosis of chemical dependency or abuse (such as alcohol, opioids, barbiturates, and amphetamines) without an accompanying medical complication are not a benefit of Texas Medicaid. Additionally, admissions for chronic diagnoses such as mental retardation, organic brain syndrome, or chemical dependency or abuse are not covered benefits for freestanding and state psychiatric facilities without an accompanying medical complication or medical condition.

Supporting documentation (certification of need) must be documented in the individual client’s record. This documentation must be maintained by each facility for a minimum of five years and be readily available for review whenever requested by HHSC or its designee.

Refer to: Subsection 3.2.4, "Prior Authorization and Documentation Requirements" in this handbook for more information about documentation requirements.

3.11.3 Prior Authorization and Documentation Requirements

Prior authorization is required under CCIP for admission to freestanding psychiatric facilities or state psychiatric hospitals for clients birth through 20 years of age.

A toll-free telephone and fax line are available to complete the authorization process. Contact the TMHP CCIP Unit at 1-800-213-8877 or fax to 1-512-514-4211.

Authorization procedures and approved providers may be different for managed care clients. Contact the client’s specific health care plan for details.

A completed Psychiatric Inpatient Initial Admission Request Form or Psychiatric Inpatient Extended Stay Request Form prescribing the inpatient psychiatric services must be signed and dated by the admitting physician familiar with the client prior to requesting authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures are not accepted. The completed Psychiatric Inpatient Initial Admission Request Form or Psychiatric Inpatient Extended Stay Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the hospital's medical record for the client.
Documentation of medical necessity for inpatient psychiatric care must specifically address the following issues:

- Why the ambulatory care resources in the community cannot meet the treatment needs of the client.
- Why inpatient psychiatric treatment under the care of a psychiatrist is required to treat the acute episode of the client.
- How the services can reasonably be expected to improve the condition or prevent further regression of the client's condition in a proximate time period.

Psychological or neuropsychological testing performed in a freestanding or state psychiatric facility does not require prior authorization; however, the facility must maintain documentation that supports medical necessity for the testing and the testing results of any psychological or neuropsychological testing service performed while the client is an inpatient.

For initial inpatient admissions to freestanding and state psychiatric facilities, the completed Psychiatric Inpatient Initial Admission Request Form must be faxed no later than the date of the client's admission unless the admission is after 5 P.M., on a holiday or a weekend. When the admission occurs after 5 P.M., on a holiday or a weekend, the CCIP unit must receive the faxed request on the next business day following admission. If the admission occurs after 2 P.M., the provider must contact the CCIP unit by telephone and fax the Psychiatric Inpatient Initial Admission Request Form to the CCIP unit on the following business day.

- To complete the prior authorization process the provider must fax the completed Psychiatric Inpatient Admission Form to the CCIP prior authorization unit.
- To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of medical necessity for the services requested.

Initial admissions may be prior authorized for a maximum of five days based on the client's Medicaid eligibility and documentation of medical necessity.

- All psychiatric admission requests for clients birth through 12 years of age will be reviewed by a psychiatrist.
- Psychiatric admission requests for clients 12 through 20 years of age will be reviewed by a mental health professional. Any requests for psychiatric admissions which do not meet the criteria for admission will be referred to a psychiatrist for final determination.

Providers must submit a Psychiatric Inpatient Extended Stay Request Form to the CCIP unit requesting prior authorization for a continuation of stay. Requests for a continuation of stay must be received on or before the last day authorized or denied. The provider is notified of the decision in writing via fax by the CCIP unit. If the date of the CCIP unit determination letter is on or after the last day authorized or denied, the request for continuation of stay is due by 5:00 p.m. of the next business day.

The Psychiatric Inpatient Extended Stay Request Form must reflect the need for continued stay in relation to the original need for admission. Any change in the client's diagnosis must be noted on the request. Additional documentation or information supporting the need for continued stay may be attached to the form. Up to seven days may be authorized for an extension request.

### 3.11.3.1 Medicaid Clinical Criteria for Inpatient Psychiatric Care For Clients

The client must have a valid AXIS I, DSM-IV-TR diagnosis as the principle admitting diagnosis and outpatient therapy or partial hospitalization has been attempted and failed, or a psychiatrist has documented reasons why an inpatient level of care is required. The client's Axis II diagnosis must also be included on the request for inpatient psychiatric treatment.
The client must meet at least one of the following criteria:

- The client is presently a danger to self, demonstrated by at least one of the following:
  - Recent suicide attempt or active suicidal threats with a deadly plan and an absence of appropriate supervision or structure to prevent suicide.
  - Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent self-mutilation (i.e. intentionally cutting/burning self).
  - Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or retardation resulting in a significant inability to care for self.
  - Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the client.
  - The medical (AXIS III) diagnosis must be treatable in a psychiatric setting.

- The client is a danger to others. This behavior should be attributable to the client’s specific AXIS I or DSM-IV-TR diagnosis and can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:
  - Recent life-threatening action or active homicidal threats of same with a deadly plan and availability of means to accomplish the plan with likelihood of acting on the threat.
  - Recent serious assaultive or sadistic behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent assaultive behavior.
  - Active hallucinations or delusions directing or likely to lead to serious harm of others.

- The client exhibits acute onset of psychosis or severe thought disorganization, or there is significant clinical deterioration in the condition of someone with a chronic psychosis, rendering the client unmanageable and unable to cooperate in treatment, and the client is in need of assessment and treatment in a safe and therapeutic setting.

- The client has a severe eating or substance abuse disorder which requires 24-hour-a-day medical observation, supervision and intervention.

- The client exhibits severe disorientation to person, place or time.

- The client’s evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors and other behaviors which may also include physical, psychological or sexual abuse.

- The client requires medication therapy or complex diagnostic evaluation where the client’s level of functioning precludes cooperation with the treatment regimen.

- The client is involved in the legal system, manifests psychiatric symptoms and is ordered by court to undergo a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs.

The proposed treatment/therapy requires 24-hour-a-day medical observation, supervision, and intervention and must include all of the following:

- Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board (TMB) and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment/therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.

- Implementation of an individualized treatment plan.
• Provision of services which can reasonably be expected to improve the client's condition or prevent further regression so that a lesser level of care can be implemented.

Proper treatment of the client’s psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist and is being provided in the least restrictive environment available, and ambulatory care resources available in the community do not meet the client’s needs.

3.11.3.2 Continued Stays

Continued stays are considered when the client meets at least one of the criteria from above and has a treatment/therapy regimen that includes all of the following:

• Active supervision by a psychiatrist with the appropriate credentials as determined by the TMB and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment/therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.

• Treatment/therapy requires an inpatient level of care.

• Initial discharge plans have been formulated and actions have been taken toward implementation, including documented contact with a local mental health provider.

Continued stays are considered for children and adolescents whose discharge plan does not include returning to their natural home: If the party responsible for placement has provided the provider with three documented placement options for which the child meets admission criteria, but which cannot accept the child, up to five days may be authorized, per request, to allow alternative placement to be located. Up to three 5-day extensions may be authorized.

3.11.3.3 Court-Ordered Services

A request for prior authorization of court-ordered services must be submitted no later than seven calendar days after the date on which the services began.

Court-ordered services are not subject to the 12-hour system limitation per provider per day when billed with modifier H9.

Court-ordered services are not subject to the five day admission limitation or the seven day continued stay limitation. Court-ordered services include:

• Mental health commitments

• Condition of probation (COP)

For court-ordered admissions, a copy of the doctor's certificate and all court-ordered commitment papers signed by the judge must be submitted with the psychiatric hospital inpatient form.

Specific court-ordered services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as mandated by the court. A copy of the court document signed by the judge must accompany prior authorization requests. If the requested services differ from the court order, the additional services will be reviewed for medical necessity. Requested services beyond those court-ordered are subject to medical necessity review.

3.11.3.4 Denials

All prior authorization requests not submitted or received by the TMHP CCIP unit in accordance with established policies are denied through the submission date, and claim payment is not made for the dates of service denied.
All denials may be appealed. The TMHP CCIP unit must receive these appeals within 15 days of the TMHP CCIP unit denial notice.

- Appeals of a denial for an initial admission and/or a continued stay must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration.
- Appeals of a denial for late submission of information must be accompanied by documentation which the provider believes supports the compliance with HHSC claims submission guidelines.
- Appeals are reviewed first by an experienced psychiatric LCSW (Licensed Clinical Social Worker) or an RN (Registered Nurse) to determine if the required criteria is documented and then forwarded to a psychiatrist for final determination. The provider will be notified of all denial determinations in writing via fax by the TMHP CCIP unit.

3.11.3.5 Utilization Review

All decisions on requests and/or appeals for admission or continuation of stay are responded to in writing and faxed to the provider by TMHP.

Utilization review activities of all Medicaid services provided by hospitals reimbursed under either the DRG prospective payment system or TEFRA are required by Title XIX of the Social Security Act, Sections 1902 and 1903. The review activities are performed through a series of monitoring systems developed to ensure that services are appropriate to need and in the optimum quality and quantity. Clients and providers are subject to utilization review monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and the quality of care reflected by the choice of services provided, type of provider involved, and settings in which care was delivered. This monitoring ensures cost-effective administration of Texas Medicaid.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Utilization review may also occur by an examination of particular claims or services not within the regular screening review when a specific utilization review is requested by HHSC or the Texas Attorney General's Office.

3.11.3.6 Retrospective Utilization Review

All admissions are subject to retrospective utilization review. The complete medical record is used to evaluate the medical necessity of admission, each day of continued inpatient care, and the quality of care provided.

Reminder: Admissions and continued stays must be certified in accordance with 42 CFR Sections 441.150 through 441.182. Certification of need must be established and maintained as documentation for each Medicaid client. Each facility must maintain this documentation and make it readily available for review whenever requested by HHSC or its designee.

For admissions of Medicaid-eligible clients or admission of clients who gain Medicaid eligibility while in the facility, the certification of need must be completed by the interdisciplinary team responsible for the POC within 14 days of admission.

Documentation of medical necessity for inpatient psychiatric care must specifically address the following issues:

- Why the ambulatory care resources in the community cannot meet the treatment needs of the client.
- Why inpatient psychiatric treatment under the care of a psychiatrist is required to treat the acute episode of the client.
- How the services can reasonably be expected to improve the condition or prevent further regression of the client’s condition in a proximate time period.
A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

### 3.11.4 Claims Information

Providers must submit claims for inpatient psychiatric hospital services to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form. Providers must purchase the UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

The PAN must be identified in Block 63 of the UB-04 CMS-1450 or the appropriate field of the electronic form.

Use of revenue code 124 is restricted to freestanding psychiatric hospitals. Acute care hospital claims billing charges using revenue code 124 are manually changed to reflect the same charges using revenue code 120. TMHP must receive claims for payment consideration according to filing deadlines for inpatient claims.

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

Section 6, Claims Filing *(Vol. 1, General Information)* for general information about claims filing.


Form CH.26, “Inpatient Psychiatric Hospital/Facility (CCP Only)” in this handbook for a claim form example.

### 3.11.5 Reimbursement

Freestanding psychiatric facilities are reimbursed a provider-specific prospective payment system rate in accordance with 1 TAC §355.8063 subsection (v) and (w).

For more information on cost reports for their facility, providers should call Medicaid Audit at 1-512-506-6117.

### 3.12 Inpatient Rehabilitation Hospital (Freestanding) (CCP)

#### 3.12.1 Enrollment

Note: *Rehabilitation provided at an acute care facility is covered through Texas Medicaid fee-for-service.*

To be eligible to participate in CCP, a freestanding rehabilitation hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Texas Medicaid enrolls and reimburses freestanding inpatient rehabilitation hospitals for CCP services and Medicare deductible/coinsurance. The information in this section is applicable to CCP services only.

Refer to: Subsection 3.2.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.

#### 3.12.1.1 Continuity of Hospital Eligibility Through Change of Ownership

Under procedures set forth by the CMS and Department of Health and Human Services, a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued subject to the following requirements:

- Recertification as a Title XVIII (Medicare) hospital must be obtained.
- A new Title XIX (Medicaid) agreement between the hospital and HHSC under new ownership must be obtained.
Providers can obtain the Medicaid hospital participation agreement by contacting TMHP Provider Enrollment.

### 3.12.2 Services/Benefits and Limitations

*Note:* Rehabilitation provided at an acute care facility is covered through Medicaid fee-for-service.

Inpatient rehabilitation hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Conditions requiring rehabilitation may be acute, exacerbations of chronic conditions, or chronic conditions. A condition is considered to be acute or an exacerbation of a chronic condition only during the 6 months from the onset date of the acute condition or the exacerbation of the chronic condition. Requests for services beyond this time period may be considered on a case-by-case basis through CCP.

#### 3.12.2.1 Comprehensive Treatment

The intensity of necessary rehabilitative service cannot be provided in the outpatient setting.

Comprehensive rehabilitation treatment must be under the leadership of a physician. Comprehensive rehabilitation treatment must be an active interdisciplinary team, defined as at least two types of therapies.

Comprehensive treatment must consist of at least two appropriate physical modalities designed to resolve or improve the client’s condition (PT, OT, and ST), and must be provided for a minimum of 3 hours per day for 5 days per week.

#### 3.12.2.2 Goal

The goal is to return the client to a functional or more functional lifestyle in a reasonable period of time.

#### 3.12.3 Prior Authorization and Documentation Requirements

Prior authorization is required. After receiving the documentation establishing the medical necessity and plan of medical care by the treating physician, prior authorization is considered by CCP for both the initial service and an extension of service. A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

All inpatient rehabilitation services provided to clients who are birth through 20 years of age in a freestanding rehabilitation facility require prior authorization.

Prior authorization will be considered when the client has met all of the following criteria:

- The client has an acute problem and/or an acute exacerbation of a chronic problem resulting in a significant decrease in functional ability that will benefit from inpatient rehabilitation services.
- The intensity of necessary rehabilitative service cannot be provided in the outpatient setting.
- The client requires, and will receive, multidisciplinary team care, defined as at least 2 therapies (occupational, physical, and/or speech therapy).
- This therapy will be provided for a minimum of 3 hours per day, 5 days per week.

The physician and the provider must maintain all documentation in the client’s medical record.

Inpatient rehabilitation may be prior authorized for up to 2 months when the attending physician submits documentation of medical necessity. The treatment plan must indicate that the client is expected to improve within a 60-day period and be restored to a more functional lifestyle for an acute condition or the previous level of function for an exacerbation of a chronic condition.

Requests for subsequent services for increments up to 60 days may be prior authorized based on medical necessity. Requests for prior authorization of subsequent services must be received before the end-date of the preceding prior authorization.
A prior authorization request for an additional 60 days of therapy will be considered with documentation supporting medical necessity.

Supporting documentation for an initial request must include the following:

- A signed physician’s order including the physician’s original handwritten signature (stamped signatures and dates are not accepted). The physician’s signature is valid for no more than 90 days prior to the requested start of care date.
- A CCP Prior Authorization Form signed and dated by the physician.
- A current therapy evaluation with the documented age of the client at the time of evaluation.
- Therapy goals related to the client’s individual needs; goals may include improving or maintaining function, or slowing of deterioration of function.
- An updated written comprehensive treatment plan established by the attending physician and/or by the therapist to be followed during the inpatient rehabilitation admission that:
  - Is under the leadership of a physician and includes a description of the specific therapy being prescribed, diagnosis, treatment goals related to the client’s individual needs, and duration and frequency of therapy.
  - Includes the date of onset of the illness or injury requiring the rehabilitation admission.
  - Includes the requested dates of service.
  - Incorporates an active interdisciplinary team.
  - Consists of at least 2 appropriate physical modalities (PT, OT, and ST) designed to resolve or improve the client’s condition.
  - Include a minimum of 3 hours of team interaction with the client every day, 5 days per week.
- In addition to the documentation for an initial request, supporting documentation for a request for subsequent services must include the following:
  - A brief synopsis of the outcomes of the previous treatment relative to the debilitating condition
  - The expected results to be achieved by an extension of the active treatment plan, and the time interval at which this extension outcome should be achieved
  - Discussion why the initial two months of inpatient rehabilitation has not met the client’s needs and why the client cannot be treated in an outpatient setting

3.12.4 Claims Information

Providers must submit inpatient rehabilitation hospital services to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form. Providers must purchase the UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

For PT, OT, and ST services, freestanding rehabilitation and acute care hospitals can use revenue codes 128, 420, 424, 430, 434, 440, and 444.

TMHP must receive claims for payment consideration according to filing deadlines for inpatient claims. Claims for services that have been authorized must reflect the PAN in Block 63 of the UB-04 CMS-1450 paper claim form or its electronic equivalent.
Refer to: Section 3, TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.
Section 6, Claims Filing (Vol. 1, General Information) for general information about claims filing.
Form CH.27, “Inpatient Rehabilitation Hospital (CCP Only)” in this handbook for a claim form example.

3.12.5 Reimbursement

Reimbursement for care provided in the freestanding rehabilitation hospital is made under the Texas DRG Payment System.

A new provider is given a reimbursement interim rate of 50 percent until a cost audit has been performed. Payment is calculated by multiplying the standard dollar amount (SDA) for the hospital’s payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Important: Outpatient services are not reimbursed.

The DRG payment may be enhanced by an adjusted day or cost outlier payment, if applicable. For example, the limit per spell of illness under Texas Medicaid guidelines is waived for clients who are birth through 20 years of age. An outlier payment may be made to compensate for unusual resource utilization or a lengthy stay.

The following criteria must be met to qualify for a day outlier payment. Inpatient days must exceed the DRG day threshold for the specific DRG. Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 70 percent of the per diem amount of a full DRG payment. The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

To establish a cost outlier, TMHP determines the outlier threshold by using the greater of the full DRG payment amount multiplied by 1.5 or an amount determined by selecting the lesser of the universe mean of the current base year data multiplied by 11.14 or the hospital’s SDA multiplied by 11.14.

The calculation that yields the greater amount is used in calculating the actual cost outlier payment. The outlier threshold is subtracted from the amount of reimbursement for the admission established under the TEFRA principles and the remainder multiplied by 70 percent to determine the actual amount of the cost outlier payment.

If an admission qualifies for both a day and a cost outlier, the outlier resulting in the highest payment to the hospital is paid.

The Remittance and Status (R&S) report reflects the outlier reimbursement payment and defines the type of outlier paid, day or cost.

Providers should call the TMHP provider relations representative for their area with questions about the outlier payment.

3.12.5.1 Client Transfers

When more than one hospital provides care for the same case, the hospital furnishing the most significant amount of care receives consideration for a full DRG payment.

The other hospital(s) is/are paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility. The DRG modifier PT on the R&S report indicates per diem pricing related to a client transfer.
Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. The facility must bill only one claim.

After all hospital claims have been submitted, TMHP performs a post-payment review to determine whether the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

4. SCHOOL HEALTH AND RELATED SERVICES (SHARS)

4.1 Overview

Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as SHARS. The oversight of SHARS is a cooperative effort between the Texas Education Agency (TEA) and HHSC. SHARS allows local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services that are documented in a student’s Individualized Education Program (IEP). SHARS are provided to students who meet all of the following requirements:

- Are 20 years of age or younger and eligible for Medicaid
- Meet eligibility requirements for special education described in the *Individuals with Disabilities Education Act* (IDEA)
- Have IEPs that prescribe the needed services

Services covered by SHARS includes:

- Audiology services
- Counseling
- Nursing services
- Physician services
- Occupational therapy (OT)
- Physical therapy (PT)
- Psychological services, including assessments (procedure code 96101)
- Speech therapy (ST)
- Personal care services (PCS)
- Transportation in a school setting

These services must be provided by qualified personnel who are under contract with or employed by the school district. Furthermore, the school district must be enrolled as a SHARS Medicaid provider in order to bill Texas Medicaid for these services.

*Important:* The Centers for Medicare & Medicaid Services (CMS) requires SHARS providers to participate in the Random Moment Time Study (RMTS), to be eligible to bill and receive reimbursement for SHARS direct services, and submit an annual SHARS Cost Report.

4.1.1 Eligibility Verification

The following are means to verify Medicaid eligibility of students:

- Verify electronically through third-party software or TexMedConnect.
• School districts may inquire about the eligibility of a student by submitting the student’s Medicaid number or two of the following: name, date of birth, or Social Security number. A search can be narrowed further by entering the county code or sex of the student. Verifications may be submitted in batches without limitations on the number of students.

• Contact the Automated Inquiry System (AIS) at 1-800-925-9126.

4.2 Enrollment

4.2.1 SHARS Enrollment

To enroll in Texas Medicaid as a SHARS provider, school districts, including public charter schools, must employ or contract with individuals or entities that meet certification and licensing requirements in accordance with the Texas Medicaid State Plan for SHARS to provide program services. Since public school districts are government entities, they should select “public entity” on the enrollment application.

SHARS providers are required to notify parents or guardians of their rights to a “freedom of choice of providers” (42 Code of Federal Regulations [CFR] §431.51) under Texas Medicaid. Most SHARS providers currently provide this notification during the initial Admission, Review, and Dismissal (ARD) process. If a parent requests that someone other than the employees or currently contracted staff of the SHARS provider (school district) provide a required service listed in the student’s IEP, the SHARS provider must make a good faith effort to comply with the parent’s request. The SHARS provider can negotiate with the requested provider to provide the services under contract. The requested provider must meet, comply with, and provide all of the employment criteria and documentation that the SHARS provider normally requires of its employees and currently contracted staff. The SHARS provider can negotiate the contracted fee with the requested provider and is not required to pay the same fee that the requested provider might receive from Medicaid for similar services. If the SHARS provider and the requested provider do not agree on a contract, the parties can determine whether a nonschool SHARS relationship in accordance with 42 CFR §431.51 is possible. If the parties do not agree to a nonschool SHARS relationship, the SHARS provider is responsible for providing the required services and must notify the parent that no contracted or nonschool SHARS relationship could be established with the requested provider.

Refer to: Subsection 2.2, “Reimbursement Methodology” in Section 2, Texas Medicaid Reimbursement (Vol. 1, General Information) for more information.

4.2.2 Nonschool SHARS Provider Enrollment

A nonschool SHARS provider must have either a current provider identifier as a Texas Medicaid provider of the IEP service or meet all of the eligibility requirements to obtain a provider identifier as a Texas Medicaid provider of the IEP service. For example, a nonschool SHARS provider of speech therapy must meet all provider criteria to provide Texas Medicaid fee-for-service speech therapy and cannot hold only a state education certificate as a speech therapist.

To be enrolled in Texas Medicaid as a nonschool SHARS provider, the enrollment packet must contain an affiliation letter that:

• Is written on school district letterhead

• Is signed by the school district superintendent or designee

• Contains assurances that the school district will reimburse the state share to HHSC for any Texas Medicaid payments made to the nonschool SHARS provider for the listed student and service

• Lists the Medicaid number and Social Security number of the student to be served and notes the type of IEP SHARS service to be provided

• Acknowledges that the nonschool SHARS provider has agreed in writing to:
  • Provide the listed SHARS service shown in the student’s IEP
• Provide the listed SHARS service in the least restrictive environment as set forth in the IEP
• Maintain and submit all records and reports required by the school district to ensure compliance with the IEP and compliance with IEP documentation and billing requirements
• States the effective period for this nonschool SHARS provider arrangement

A separate affiliation letter is required for each Texas Medicaid client to be served by the nonschool SHARS provider. A nonschool SHARS provider is required to have a separate two-digit suffix for each school district with which it is affiliated. For example, if a nonschool SHARS provider has written agreements with Anywhere Independent School District (ISD) for two students and with Somewhere ISD for one student, then the nonschool SHARS provider would submit its claims for the two students from Anywhere ISD under provider identifier 1234567-01 and associated National Provider Identifier (NPI) number if submitting a paper claim. The SHARS provider would submit its claims for the one student from Somewhere ISD under provider identifier 1234567-02 and associated NPI number if submitting a paper claim. The nonschool SHARS provider would submit two affiliation letters from Anywhere ISD to TMHP Provider Enrollment (one for each student served) and one affiliation letter from Somewhere ISD.

Since nonschool SHARS providers are private, nonpublic entities, they should select “private entity” on the enrollment application.

Nonschool SHARS services include audiology services, counseling services, nursing services, OT, PT, speech therapy services, and psychological services delivered in an individual setting. Nonschool SHARS services do not include evaluation/assessment, physician services, personal care services, or transportation.

4.2.3 Private School Enrollment
A private school may not participate in the SHARS program as a SHARS provider or as a nonschool SHARS provider.

4.2.4 Medicaid Managed Care Enrollment
SHARS providers do not enroll with the Medicaid Managed Care health plans. SHARS providers deliver services to all eligible Medicaid SHARS clients, including clients of the Medicaid Managed Care health plans. SHARS services are not covered by the Medicaid Managed Care health plans. SHARS services that are rendered to clients of Medicaid Managed Care are covered and may be reimbursed by TMHP. Students who are 20 years of age or younger and on a Medicaid 1915(c) waiver program are covered and may be reimbursed by TMHP.

4.3 Services/Benefits, Limitations, and Prior Authorization
All of the SHARS procedures listed in the following sections require a valid International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code. SHARS include audiology services, counseling, physician services, nursing services, OT, PT, psychological services, speech therapy services, personal care services, and transportation.

Reminder: SHARS are the services determined by the ARD committee to be medically necessary and reasonable to ensure that children with disabilities who are eligible for Medicaid and 20 years of age or younger receive the benefits accorded to them by federal and state law in order to participate in the educational program.

4.3.1 Audiology
Audiology and hearing aid services for clients with suspect or permanent hearing lost that were available through DSHS until September 1, 2009, that have been transitioned to Texas Medicaid may only be reimbursed to appropriately-enrolled audiologists and hearing aid providers, not SHARS providers.

Audiology evaluation services include:

- Identification of children with hearing loss
- Determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for the habilitation of hearing
- Determination of the child’s need for group and individual amplification

Audiology therapy services include the provision of habilitation activities, such as language habilitation, auditory training, audiological maintenance, speech reading (lip reading), and speech conversation.

Audiology services must be provided by a professional who holds a valid state license as an audiologist or by an audiology assistant who is licensed by the state when the assistant is acting under the supervision of a qualified audiologist. State licensure requirements are equal to American Speech-Language-Hearing Association (ASHA) certification requirements.

Audiology evaluation is billable on an individual (92506) basis only. Audiology therapy is billable on an individual (92507) and group (92508) basis. Only the time spent with the student present is billable; time spent without the student present is not billable. Session notes for evaluations are not required; however, documentation must include the billable start time, billable stop time, and total billable minutes with a notation of the activity performed (e.g., audiology evaluation). Session notes are required for therapy. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

### 4.3.1.1 Audiology Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
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<th>Therapist or Assistant</th>
</tr>
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<tbody>
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<td>Individual</td>
<td>Licensed audiologist</td>
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</tr>
<tr>
<td>1, 2, or 9</td>
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<td>Licensed audiologist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92508 with modifier U1</td>
<td>Group</td>
<td>Licensed/certified assistant</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office or school; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 4.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for audiology evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct audiology therapy (group and/or individual) is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### 4.3.2 Counseling Services

Counseling services are provided to help a child with a disability benefit from special education and must be listed in the IEP. Counseling services include, but are not limited to, the following:

- Assisting the child or parents in understanding the nature of the child’s disability
- Assisting the child or parents in understanding the special needs of the child
• Assisting the child or parents in understanding the child’s development
• Health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors that are important to the prevention, treatment, or management of physical health problems
• Assessing the need for specific counseling services

Counseling services must be provided by a professional who has one of the following certifications or licensures: a licensed professional counselor (LPC), a licensed clinical social worker (LCSW) or a licensed marriage and family therapist (LMFT).

Counseling services are billable on an individual (96152) or group (96153) basis. Session notes are required and documentation must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency counseling services as long as the student’s IEP includes a behavior improvement plan that documents the need for emergency services.

4.3.2.1 Counseling Services Billing Table

<table>
<thead>
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<th>Procedure Code</th>
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</tr>
</thead>
<tbody>
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<td>96152 with modifier UB</td>
<td>Individual</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>96153 with modifier UB</td>
<td>Group</td>
</tr>
</tbody>
</table>

*Place of Service: 1 = Office or School; 2 = Home; 9 = Other Locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 4.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time (individual and/or group) is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

4.3.3 Psychological Testing and Services

4.3.3.1 Psychological Testing

Evaluations/assessments include activities related to the evaluation of the functioning of a student for the purpose of determining eligibility, the needs for specific SHARS services, and the development or revision of IEP goals and objectives. An evaluation/assessment is billable if it leads to the creation of an IEP for a student with disabilities who is eligible for Medicaid and who is 20 years of age or younger, whether or not the IEP includes SHARS.

Evaluations/assessments (procedure code 96101) must be provided by a professional who is a licensed specialist in school psychology (LSSP), a licensed psychologist, or a licensed psychiatrist in accordance with 19 TAC §89.1040(b)(1) and 34 CFR §300.136(a)(1).

Evaluation/assessment billable time includes the following:

• Psychological, educational, or intellectual testing time spent with the student present
• Necessary observation of the student associated with testing
• A parent/teacher consultation with the student present that is required during the assessment because a student is unable to communicate or perform certain activities
• Time spent without the student present for the interpretation of testing results

Time spent gathering information without the student present or observing a student is not billable evaluation/assessment time.
Session notes are not required; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note which assessment activity was performed (e.g., testing, interpretation, or report writing).

**Psychological Testing Billing**

The recommended maximum billable time for psychological testing is eight hours (8.0 units) over a 30 day period. Time spent for the interpretation of testing results without the student present is billable time. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

One unit (1.0) is equivalent to one hour or 60 minutes. Providers may bill in partial hours, expressed as 1/10th of an hour (six-minute segments). For example, express 30 minutes as a billed quantity of 0.5.

*Refer to:* Subsection 4.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

When billing, minutes of Evaluations/Assessments are not accumulated over multiple days. Minutes of Evaluations/Assessments can only be billed per calendar day.

**4.3.3.2 Psychological Services**

Psychological services are counseling services provided to help a child with a disability benefit from special education and must be listed in the IEP.

Psychological services must be provided by a licensed psychiatrist, a licensed psychologist, or an LSSP. Nothing in this rule prohibits public schools from contracting with licensed psychologists and licensed psychological associates who are not LSSPs to provide psychological services, other than school psychology, in their areas of competency. School districts may contract for specific types of psychological services, such as clinical psychology, counseling psychology, neuropsychology, and family therapy, that are not readily available from the LSSP who is employed by the school district. Such contracting must be on a short-term or part-time basis and cannot involve the broad range of school psychological services listed in 22 TAC §465.38(1)(B).

All psychological services are billable on an individual (96152) or group (96153) basis. Session notes are required. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency psychological services as long as the student’s IEP includes a behavior improvement plan that documents the need for the emergency services.

**Psychological Services Billing Table**

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual/Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>96152 with modifier AH</td>
<td>Individual</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>96153 with modifier AH</td>
<td>Group</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office or school; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

*Refer to:* Subsection 4.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for direct psychological therapy (group and/or individual) is a total of one hour per day for nonemergency situations. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.
4.3.4 Nursing Services

Nursing services are skilled nursing tasks, as defined by the Texas Board of Nursing (BON), that are included in the student’s IEP. Nursing services may be direct nursing care or medication administration. Examples of reimbursable nursing services include, but are not limited to, the following:

- Inhalation therapy
- Ventilator monitoring
- Nonroutine medication administration
- Tracheostomy care
- Gastrostomy care
- Ileostomy care
- Catheterization
- Tube feeding
- Suctioning
- Client training
- Assessment of a student’s nursing and personal care services needs

Direct nursing care services are billed in 15-minute increments and medication administration is reimbursed on a per-visit increment. The registered nurse (RN) or advanced practice registered nurse (APRN) determines whether these services must be billed as direct nursing care or medication administration.

Nursing services must be provided by an RN, an APRN (including nurse practitioners [NPs] and clinical nurse specialists [CNSs]), licensed vocational nurse/licensed practical nurse (LVN/LPN), or a school health aide or other trained, unlicensed assistive person delegated by an RN or APRN.

Nursing services are billable on an individual or group basis. Only the time spent with the student present is billable. Time spent without the student present is not billable. Session notes are not required for nursing services; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of nursing service that was performed.

4.3.4.1 Nursing Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Unit of Service</th>
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</thead>
<tbody>
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<td>1, 2, or 9</td>
<td>T1002 with modifier TD</td>
<td>Individual</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1002 with modifier TD and UD</td>
<td>Group</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1502 with modifier TD</td>
<td>Medication administration, per visit</td>
<td></td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1002 with modifier U7</td>
<td>Delegation, individual</td>
<td>15 minutes</td>
</tr>
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<td>1, 2, or 9</td>
<td>T1002 with modifier U7 and UD</td>
<td>Delegation, group</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office or school; 2=home; 9=other locations

Modifier TD = nursing services provided by an RN or APRN
Modifier U7 = nursing services delivered through delegation.
Modifier TE = nursing services delivered by an LVN/LPN
Modifier UD = nursing services delivered on a group basis
The Medicaid-allowable fee is determined based on 15-minute increments. Providers must use a 15-minute unit of service for billing.

All of the nursing services minutes that are delivered to a student during a calendar day must be added together before they are converted to units of service. Do not convert minutes of nursing services separately for each nursing task that was performed.

Minutes of nursing services cannot be accumulated over multiple days. Minutes of nursing services can only be billed per calendar day. If the total number of minutes of nursing services is less than eight minutes for a calendar day, then no unit of service can be billed for that day, and that day’s minutes cannot be added to minutes of nursing services from any previous or subsequent days for billing purposes.

Refer to: Subsection 4.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for direct nursing services is four hours per day. The recommended maximum billable units for procedure code T1502 with modifier TD, T1502 with modifier U7, or T1502 with modifier TE is a total of four medication administration visits per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### 4.3.5 Occupational Therapy

In order for a student to receive occupational therapy (OT) through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribed the OT must be provided.

OT evaluation services include determining what services, assistive technology, and environmental modifications a student requires for participation in the special education program.

OT includes:

- Improving, developing, maintaining, or restoring functions impaired or lost through illness, injury, or deprivation
- Improving the ability to perform tasks for independent functioning when functions are impaired or lost
- Preventing, through early intervention, initial or further impairment or loss of function

OT must be provided by a professional who is licensed by the Texas Board of Occupational Therapy Examiners or a certified occupational therapist assistant (COTA) acting under the supervision of a qualified occupational therapist.
OT evaluation is billable on an individual (procedure code 97003) basis only. OT is billable on an individual (procedure code 97530) or group (procedure code 97150) basis. The occupational therapist or COTA can only bill for time spent with the student present, including time spent assisting the student with learning to use adaptive equipment and assistive technology. Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time), report writing, and time spent manipulating or modifying the adaptive equipment, is not billable. Session notes are not required for procedure code 97003; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., OT evaluation). Session notes are required for procedure codes 97530 and 97150. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

4.3.5.1 Occupational Therapy Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
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<td>1, 2, or 9</td>
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<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97150 with modifier GO and U1</td>
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<td>Licensed/certified assistant</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97530 with modifier GO</td>
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<td>Licensed therapist</td>
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<tr>
<td>1, 2, or 9</td>
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<td>Individual</td>
<td>Licensed/certified assistant</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office or school; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 4.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for OT evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (group or individual) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

4.3.6 Personal Care Services

Personal care services are provided to help a child with a disability or chronic condition benefit from special education. Personal care services include a range of human assistance provided to persons with disabilities or chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. An individual may be physically capable of performing activities of daily living (ADLs) and instrumental ADLs (IADLs) but may have limitations in performing these activities because of a functional, cognitive, or behavioral impairment.

Refer to: Subsection 3.8, “Personal Care Services (PCS) (CCP)” in this handbook for a list of ADLs and IADLs.

For personal care services to be billable, they must be listed in the student’s IEP. Personal care services are billable on an individual (T1019 with modifier U5 or U6) or group (T1019 with modifier U5 and UD or U6 and UD) basis. Session notes are not required for procedure codes T1019 with modifier U5 or T1019 with modifier U5 and UD; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of personal care service that was performed. Procedure codes T1019 with modifier U6 and T1019 with modifier U6 and UD are billed using a one-way trip unit of service.
**4.3.6.1 Personal Care Services Billing Table**

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
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</thead>
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<td>1, 2, or 9</td>
<td>T1019 with modifier U5</td>
<td>Individual, school</td>
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</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U5 and UD</td>
<td>Group, school</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U6</td>
<td>Individual, bus</td>
<td>Per one-way trip</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U6 and UD</td>
<td>Group, bus</td>
<td>Per one-way trip</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office or school; 2=home; 9=other locations

**Refer to:** Subsection 4.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable units for T1019 with modifier U6 or T1019 with modifier U6 and UD is a total of four one-way trips per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended units of service are billed.

**4.3.7 Physical Therapy**

In order for a student to receive PT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribes the PT must be provided.

PT evaluation includes evaluating the student’s ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems.

PT is provided for the purpose of preventing or alleviating movement dysfunction and related functional problems.

PT must be provided by a professional who is licensed by the Texas Board of Physical Therapy Examiners or a licensed physical therapist assistant (LPTA) acting under the supervision of a qualified physical therapist.

PT evaluation is billable on an individual (procedure code 97001) basis only. PT is billable on an individual (procedure code 97110) or group (procedure code 97150) basis. The physical therapist can only bill time spent with the student present, including time spent helping the student to use adaptive equipment and assistive technology. Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time) and report writing, is not billable. Session notes are not required for procedure code 97001; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., PT evaluation). Session notes are required for procedure codes 97110 and 97150. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.
4.3.7.1 Physical Therapy Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
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<td>97150 with modifier GP and U1</td>
<td>Group</td>
<td>Licensed/certified assistant</td>
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*Place of Service: 1=office or school; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 4.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for PT evaluation is three hours, which may be billed within a 30 day period. The recommended maximum billable time for direct therapy (group or individual) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

4.3.8 Physician Services

Diagnostic and evaluation services are reimbursable under SHARS physician services. Physician services must be provided by a licensed physician (MD or DO). A physician prescription is required before PT or OT services may be reimbursed under SHARS. Speech therapy services require either a physician prescription or a referral from a licensed speech language pathologist (SLP) before the speech therapy services may be reimbursed under the SHARS program. The school district must maintain the prescription/referral. The prescription/referral must relate directly to specific services listed in the IEP. If a change is made to a service on the IEP that requires a prescription/referral, the prescription/referral must be revised accordingly.

The expiration date for the physician prescription is the earlier of either the physician’s designated expiration date on the prescription or three years, in accordance with the IDEA three-year re-evaluation requirement.

SHARS physician services are billable only when they are provided on an individual basis. The determination as to whether or not the provider needs to see the student while reviewing the student’s records is left up to the professional judgment of the provider. Therefore, billable time includes the following:

- The diagnosis/evaluation time spent with the student present
- The time spent without the student present reviewing the student’s records for the purpose of writing a prescription/referral for specific SHARS services
- The diagnosis/evaluation time spent with the student present, and/or the time spent without the student present reviewing the student’s records for the evaluation of the sufficiency of an ongoing SHARS service to see whether any changes are needed in the current prescription or referral for that service

Session notes are not required for procedure code 99499; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the medical activity that was performed.
4.3.8.1 Medical Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
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<tbody>
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<td>99499</td>
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</table>

*Place of Service: 1 = Office or School; 2 = Home; 9 = Other Locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 4.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

4.3.9 Speech Therapy

4.3.9.1 Referral

The name and complete address or the provider identifier or license number of the referring licensed physician or licensed SLP is required before speech therapy services can be billed under SHARS. A licensed SLP’s evaluation and recommendation for the frequency, location, and duration of speech therapy serves as the speech referral.

4.3.9.2 Description of Services

Speech evaluation services include the identification of children with speech or language disorders and the diagnosis and appraisal of specific speech and language disorders. Speech therapy services include the provision of speech and language services for the habilitation or prevention of communicative disorders.

Speech evaluation is billable on an individual (92506) basis only. Speech therapy is billable on an individual (92507) or group (92508) basis. Providers can only bill time spent with the student present, including assisting the student with learning to use adaptive equipment and assistive technology. Time spent without the student present, such as report writing and training teachers or aides to work with the student (unless the student is present during training), is not billable. Session notes are not required for procedure code 92506; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., speech evaluation). Session notes are required for procedure codes 92507 and 92508. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

4.3.9.3 Provider and Supervision Requirements

Speech therapy services are eligible for reimbursement when they are provided by a qualified speech language pathologist (SLP), who holds a Texas license or an ASHA-equivalent SLP (has a master’s degree in the field of speech language pathology and a Texas license). Speech therapy services are also eligible for reimbursement when provided by an SLP with a state education agency certification, a licensed SLP intern, or a grandfathered SLP when acting under the supervision or direction of an SLP.

The supervision must meet the following provisions:

- The supervising SLP must provide supervision that is sufficient to ensure the appropriate completion of the responsibilities that were assigned.
- The direct involvement of the supervising SLP in overseeing the services that were provided must be documented.
• The SLP who provides the direction must ensure that the personnel who carry out the directives meet the minimum qualifications set forth in the rules of the State Board of Examiners for Speech-Language Pathology and Audiology which relate to Licensed Interns or Assistants in Speech-Language Pathology.

CMS interprets “under the direction of a speech-language pathologist,” as an SLP who:
• Is directly involved with the individual under his direction.
• Accepts professional responsibility for the actions of the personnel he agrees to direct.
• Sees each student at least once.
• Has input about the type of care provided.
• Reviews the student’s speech records after the therapy begins.
• Assumes professional responsibility for the services provided.

4.3.9.4 Speech Therapy Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
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<td>92507 with modifier GN and U8</td>
<td>Individual</td>
<td>Licensed therapist</td>
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<td>1, 2, or 9</td>
<td>92507 with modifier GN and U1</td>
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<td>Licensed/certified assistant acting under the supervision or direction of a SLP</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92508 with modifier GN and U8</td>
<td>Group</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92508 with modifier GN and U1</td>
<td>Group</td>
<td>Licensed/certified assistant acting under the supervision or direction of a SLP</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office or school; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 4.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (group or individual) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

4.3.10 Transportation Services in a School Setting

Transportation services in a school setting may be reimbursed when they are provided on a specially adapted vehicle and if the following criteria are met:
• Provided to or from a Medicaid-covered service on the day for which the claim is made
• A child requires transportation in a specially adapted vehicle to serve the needs of the disabled
• A child resides in an area that does not have school bus transportation, such as those in close proximity to a school
• The Medicaid services covered by SHARS are included in the student’s IEP
• The special transportation service is included in the student’s IEP
A specially adapted vehicle is one that has been physically modified (e.g., addition of a wheelchair lift, addition of seatbelts or harnesses, addition of child protective seating, or addition of air conditioning). A bus monitor or other personnel accompanying children on the bus is not considered an allowable special adaptive enhancement for Medicaid reimbursement under SHARS specialized transportation. Specialized transportation services reimbursable under SHARS requires the Medicaid-eligible special education student has the following documented in his or her IEP:

- The student requires a specific physical adaptation or adaptations of a vehicle in order to be transported
- The reason the student needs the specialized transportation

Children with special education needs who ride the regular school bus to school with other nondisabled children are not required to have the transportation services in a school setting listed in their IEP. Also, the cost of the regular school bus ride cannot be billed to SHARS. Therefore, the fact that a child may receive a service through SHARS does not necessarily mean that the transportation services in a school setting may be reimbursed for them.

Reimbursement for covered transportation services is on a student one-way trip basis. If the student receives a billable SHARS service (including personal care services on the bus) and is transported on the school’s specially adapted vehicle, the following one-way trips may be billed:

- From the student’s residence to school
- From the school to the student’s residence
- From the student’s residence to a provider’s office that is contracted with the district
- From a provider’s office that is contracted with the district to the student’s residence
- From the school to a provider’s office that is contracted with the district
- From a provider’s office that is contracted with the district to the student’s school
- From the school to another campus to receive a billable SHARS service
- From the campus where the student received a billable SHARS service back to the student’s school

Covered transportation services from a child’s residence to school and return are not reimbursable if, on the day the child is transported, the child does not receive Medicaid services covered by SHARS (other than transportation). Documentation of each one-way trip provided must be maintained by the school district (e.g., trip log). This service must not be billed by default simply because the student is transported on a specially adapted bus.

4.3.10.1 Transportation Services in a School Setting Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>T2003</td>
<td>Per one-way trip</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office or school; 2=home; 9=other locations

The recommended maximum billable units for T2003 is a total of four one-way trips per day.

4.3.11 Prior Authorization

Prior authorization is not required for SHARS services.
4.4 Documentation Requirements

4.4.1 Record Retention
Student-specific records that are required for SHARS become part of the student’s educational records and must be maintained for seven years rather than the five years required by Medicaid. All records that are pertinent to SHARS billings must be maintained by the school district until all audit questions, appeal hearings, investigations, or court cases are resolved. Records should be stored in a readily accessible location and format and must be available for state or federal audits.

The following is a checklist of the minimum documents to collect and maintain:
- IEP
- Current provider qualifications (licenses, etc.)
- Attendance records
- Prescriptions and referrals
- Medical necessity documentation (e.g., diagnoses and history of chronic conditions or disability)
- Session notes or service logs, including provider signatures
- Supervision logs
- Special transportation logs
- Claims submittal and payment histories
- If applicable, nonschool SHARS provider’s affiliation letter and signed agreement with the district.

All services require documentation to support the medical necessity of the service rendered, including SHARS services. SHARS services are subject to retrospective review and recoupment if documentation does not support the service billed.

4.5 Claims Filing and Reimbursement

4.5.1 Claims Information
Claims for SHARS must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

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

Section 6, Claims Filing (Vol. 1, General Information) for general information about claims filing.


4.5.1.1 Appealing Denied SHARS Claims
SHARS providers that appeal claims denied for exceeding benefit limitations must submit documentation of medical necessity with the appeal. Documentation submitted with an appeal must include the pages from the IEP and ARD documents that show the authorization of the services, including the specified frequency and duration and the details of the need for additional time or the reasons for exceeding the benefit limitations.

Each page of the documentation must have the client’s name and Medicaid number.
4.5.1.2 Billing Units Based on 15 Minutes

All claims for reimbursement are based on the actual amount of billable time associated with the SHARS service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

**Reminder:** Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information may be reimbursed as a unit of 1.

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

**Examples:**

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 min–7 mins</td>
<td>0 units</td>
</tr>
<tr>
<td>8 mins–22 mins</td>
<td>1 unit</td>
</tr>
<tr>
<td>23 mins–37 mins</td>
<td>2 units</td>
</tr>
<tr>
<td>38 mins–52 mins</td>
<td>3 units</td>
</tr>
<tr>
<td>53 mins–67 mins</td>
<td>4 units</td>
</tr>
<tr>
<td>68 mins–82 mins</td>
<td>5 units</td>
</tr>
</tbody>
</table>

4.5.1.3 Billing Units Based on an Hour

All claims for reimbursement are based on the actual amount of billable time associated with the SHARS service. For those services for which the unit of service is an hour (1 unit = 60 minutes = one hour), partial units should be billed in tenths of an hour and rounded up or down to the nearest six-minute increment.

Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information may be reimbursed as a unit of 1.

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student and divide by 60 to convert to billable units of service. If the total billable minutes are not divisible by 60, the minutes are converted to partial units of service as follows:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 mins–3 mins</td>
<td>0 units</td>
</tr>
<tr>
<td>4 mins–9 mins</td>
<td>0.1 unit</td>
</tr>
<tr>
<td>10 mins–15 mins</td>
<td>0.2 unit</td>
</tr>
<tr>
<td>16 mins–21 mins</td>
<td>0.3 unit</td>
</tr>
<tr>
<td>22 mins–27 mins</td>
<td>0.4 unit</td>
</tr>
<tr>
<td>28 mins–33 mins</td>
<td>0.5 unit</td>
</tr>
<tr>
<td>34 mins–39 mins</td>
<td>0.6 unit</td>
</tr>
<tr>
<td>40 mins–45 mins</td>
<td>0.7 unit</td>
</tr>
<tr>
<td>46 mins–51 mins</td>
<td>0.8 unit</td>
</tr>
<tr>
<td>52 mins–57 mins</td>
<td>0.9 unit</td>
</tr>
</tbody>
</table>
Other examples:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>58 mins–63 mins</td>
<td>1 unit</td>
</tr>
<tr>
<td>64 mins–69 mins</td>
<td>1.1 units</td>
</tr>
<tr>
<td>70 mins–75 mins</td>
<td>1.2 units</td>
</tr>
<tr>
<td>76 mins–81 mins</td>
<td>1.3 units</td>
</tr>
<tr>
<td>82 mins–87 mins</td>
<td>1.4 units</td>
</tr>
<tr>
<td>88 mins–93 mins</td>
<td>1.5 units</td>
</tr>
</tbody>
</table>

### 4.5.2 Reimbursement

SHARS providers are reimbursed in accordance with 1 TAC §355.8443.

School districts can access their district-specific interim rates on the HHSC website at [www.hhsc.state.tx.us/medicaid/programs/rad/AcuteCare/Shars/Shars.html](http://www.hhsc.state.tx.us/medicaid/programs/rad/AcuteCare/Shars/Shars.html) and click on the link titled *Click Here To Access The Interim Rates Table.*

SHARS providers must participate in and comply with all RMTS requirements to be eligible to bill and receive Medicaid reimbursement for delivering SHARS services. For each annual SHARS Cost Report period (October 1 through September 30), if a school district does not participate in one of the three required quarterly RMTS, that school district cannot be a SHARS provider for that annual cost report period and will be required to return any Medicaid payments received for SHARS delivered during that annual cost report period. The school district can return to the SHARS program the following annual cost report period.

New SHARS providers can call the RMTS contracted vendor at 1-888-321-1225.

**Refer to:** Subsection 2.2, “Reimbursement Methodology” in Section 2, Texas Medicaid Reimbursement *Vol. 1, General Information* for more information.

Subsection 2.7, “Federal Medical Assistance Percentage (FMAP)” in Section 2, Texas Medicaid Reimbursement *Vol. 1, General Information*.

### 4.5.2.1 Random Moment Time Study (RMTS)

CMS requires existing SHARS providers to participate in the Random Moment Time Study (RMTS) to be eligible to bill and receive reimbursement for SHARS direct services. SHARS providers must comply with the [Texas Time Study Implementation Guide for Direct Medical Services and Medicaid Administrative Claiming Effective April 25, 2007](http://www.hhsc.state.tx.us/medicaid/programs/rad/AcuteCare/Shars/Shars.html), which includes but is not limited to: Mandatory Annual Program Contact training, certification of all RMTS participants for the three RMTS quarters conducted, and compliance with all sampling and participation requirements. The three RMTS quarters are October through December, January through March, and April through June.

Existing SHARS providers that do not participate in one of the three required RMTS quarters or are RMTS non-compliant cannot be a SHARS provider for that annual cost report period (October 1 through September 30) and will be required to return any Medicaid payments received for SHARS delivered during that annual cost report period. The school district can return to the SHARS program the following federal fiscal year.

New SHARS providers may not bill or be reimbursed prior to the RMTS quarter in which they begin to participate in and they must participate in all future RMTS quarters. An existing school district can only become a SHARS provider effective October 1, each year and they must participate in all three quarterly RMTS for that year to be a SHARS provider for that period.

A new school district (i.e., a newly built facility) can become a SHARS provider effective with the first day of the federal quarter in which it participates in the time study.
School districts can access the *Texas Time Study Implementation Guide for Direct Medical Services and Medicaid Claiming Effective April 25, 2007*, on the HHSC website at www.hhsc.state.tx.us/medicaid /programs/rad/AcuteCare/TS/SharsTimeStudy.html and click on the link titled *RMTS Implementation Guide*.

SHARS providers can call the RMTS contracted vendor at 1-888-321-1225.

**4.5.2.2 Certification of Funds**

SHARS providers are required to certify on a quarterly basis the amount reimbursed during the previous federal fiscal quarter. TMHP Provider Enrollment mails the quarterly Certification of Funds statement to SHARS providers after the end of each quarter of the federal fiscal year (October 1 through September 30). The purpose of the statement is to verify that the school district incurred costs on the dates of service that were funded from state or local funds in an amount equal to or greater than the combined total of its interim rates times the paid units of service. While the payments were received the previous federal fiscal quarter, the actual dates of service could have been many months prior. Therefore, the certification of public expenditures is for the date of service and not the date of payment.

In order to balance amounts in the Certification of Funds, providers will receive or have access to the Certification of Funds Claims Information Report which shows that quarter’s combined total payments for Medicaid fee-for-service claims and Medicaid PCCM claims. For help balancing the amounts in the statement, providers can contact their Provider Relations representative or the TMHP Contact Center at 1-800-925-9126.

*Refer to:* “TMHP Provider Relations” in TMHP Telephone and Address Guide (Vol 1, General Information) for more information about provider relations representatives.

The Certification of Funds statement must be:

- Signed by the business officer or other financial representative who is responsible for signing other documents that are subject to audit
- Notarized
- Returned to TMHP within 25 calendar days of the date printed on the letter

Failure to do so may result in recoupment of funds or the placement of a vendor hold on the provider’s payments until the signed Certification of Funds statement is received by TMHP. Providers must contact the TMHP Contact Center at 1-800-925-9126 if they do not receive their Certification of Funds statement.

On an annual basis, SHARS providers are required to certify through their cost reports their total, actual, incurred costs, including the federal share and the nonfederal share.

**4.5.2.3 Cost Reporting**

CMS requires annual cost reporting, cost reconciliation, and cost settlement processes for all such Medicaid SHARS services delivered by school districts. CMS requires that school districts, as public entities, not be paid in excess of their Medicaid-allowable costs and that any overpayments be recouped through the cost reconciliation and cost settlement processes. In an effort to minimize any potential recoupments, HHSC has assigned district-specific interim rates that are as close as possible to each district’s estimated Medicaid-allowable costs for providing each SHARS service.

Each SHARS provider is required to complete an annual cost report for all SHARS that were delivered during the previous federal fiscal year (October 1 through September 30). The cost report is due on or before April 1 of the year following the reporting period.
The primary purpose of the cost report is to document the provider’s costs for delivering SHARS, including direct costs and indirect costs, and to reconcile the provider’s interim payments for SHARS with its actual total Medicaid-allowable costs. The annual SHARS cost report includes a certification of funds statement which must be completed to certify the provider’s incurred actual costs. All annual SHARS cost reports that are filed are subject to desk review by HHSC or its designee.

4.5.2.4 Cost Reconciliation and Cost Settlement

The cost reconciliation process will be completed within 24 months of the end of the reporting period covered by the annual SHARS cost report. The total Medicaid-allowable costs are compared to the provider’s interim payments for SHARS delivered during the reporting period, which results in a cost reconciliation.

If a provider has not complied with all RMTS requirements or a provider’s interim payments exceed the actual certified Medicaid-allowable costs of the provider for SHARS to Medicaid clients, HHSC will recoup the federal share of the overpayment by one of the following methods:

- Offset all future claims payments to the provider until the amount of the federal share of the overpayment is recovered
- Recoup an agreed upon percentage from future claims payments to the provider to ensure recovery of the overpayments within one year
- Recoup an agreed upon dollar amount from future claims payments to ensure recovery of the overpayment within one year

If the actual certified Medicaid-allowable costs of a provider for SHARS exceed the provider’s interim payments, HHSC will pay the federal share of the difference to the provider in accordance with the final, actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

HHSC shall issue a notice of settlement that denotes the amount due to or from the provider.

5. TEXAS HEALTH STEPS (THSTEPS) DENTAL

Medicaid dental services rules are described under Title 25 Texas Administrative Code (TAC) Part 1, Chapter 33. The online version of TAC is available at the Secretary of State’s website at www.sos.state.tx.us/tac/index.shtml. All dental providers must comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including standards for documentation and record maintenance as stated in 22 TAC §108.7, Minimum Standard of Care, General, and §108.8, Records of the Dentist.

5.1 Overview

5.1.1 THSteps Dental Eligibility

The client must be Medicaid- and THSteps-eligible (birth through 20 years of age) at the time of the service request and service delivery. However, Medicaid-approved orthodontic services already in progress may be continued even after the client loses Medicaid eligibility if the orthodontic treatment is:

- Begun before the loss of Medicaid eligibility.
- Begun before the day of the client’s 21st birthday.
- Completed within 36 months of the beginning date.

When a client is due for a THSteps periodic medical or dental checkup, a message is present on the Medicaid Identification Form (H3087 or H3087 STAR) under the client’s name to remind the parent or
guardian. This reminder is not a statement of eligibility for dental services. This message is printed on the H3087 form when the client has not received any preventative dental services for 6 months.

The client is not eligible for a THSteps medical checkup or THSteps dental benefits if the client’s Medicaid Identification Form (Form H3087) or Medicaid Eligibility Verification Form (Forms H1027 and H1027-A-C) states any of the following:

- Emergency care only
- Presumptive eligibility (PE)
- Qualified Medicare beneficiary (QMB)
- Women’s Health Program

5.2 Enrollment

To become a provider of Texas Health Steps (THSteps) or Intermediate Care Facility for Persons with Mental Retardation (ICF-MR) dental services, a dentist must:

- Currently be licensed with an active status by the Texas State Board of Dental Examiners (TSBDE) or currently be licensed in the state where the service was performed.
- Practice within the scope of the provider’s professional licensure.
- Complete the Dental Provider Enrollment Application and return it to TMHP.

Providers can download and print dental provider enrollment application forms from the TMHP website at www.tmhp.com or call the TMHP Contact Center at 1-800-925-9126 to request them. Out-of-state providers should refer to subsection 2.5, “Out-of-State Medicaid Providers” in Section 2, Texas Medicaid Reimbursement (Vol. 1, General Information).

All owners of a dental practice must maintain an active license status with the TSBDE to receive reimbursement from Texas Medicaid. Any change in ownership or licensure status for any enrolled dentist must be immediately reported in writing to TMHP Provider Enrollment and will affect reimbursement by Texas Medicaid.

A dental provider cannot be enrolled if his or her dental license is due to expire within 30 days; a current license must be submitted. Dental licensure for owners of a dental practice is a requirement of the Occupations Code, Vernon’s Texas Codes Annotated (VTCA), Subtitle D, Chapters 251-267 (the Texas Dental Practice Act).

A dentist must complete the Dental Provider Enrollment Application for each separate practice location and will receive a unique provider identifier for each practice location if the application is approved.

The application form includes a written agreement with the Texas Health and Human Services Commission (HHSC).

Dental providers may enroll in the THSteps Dental program and ICF-MR Dental Programs or as a Doctor of Dentistry Practicing as a Limited Physician, or both. The enrollment requirements are different with respect to the category of enrollment.

Dentists must specify a category of practice by choosing one or more of the specialties listed in subsection 5.2.1, “Categories of Practice”.

Refer to: Subsection 1.4.2, “Maintenance of Provider Information” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

Subsection 1.1, “Provider Enrollment” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).
5.2.1 Categories of Practice
All dental providers must declare one or more of the following categories:

- General practice
- Pediatric dentist
- Periodontist
- Endodontist
- Oral and maxillofacial surgeon
- Orthodontist
- Other (prosthodontist, public health, and others)

5.2.2 THSteps Dental and ICF-MR Dental Services
A provider may enroll as an individual dentist, a group practice, or both. Regardless of the category of practice designation under THSteps Dental, providers can only bill for THSteps and ICF-MR Dental Services.

Refer to: Subsection 5.3.1, “THSteps Dental Services” in this handbook for more information on the types of dental services that are reimbursable.


5.2.3 THSteps Dental Checkup and Treatment Facilities
All THSteps dental checkup and treatment policies apply to examinations and treatment completed in a dentist’s office, a health department, clinic setting, or in a mobile/satellite unit. Enrollment of a mobile/satellite unit must be under a dentist or clinic name. Mobile units can be a van or any temporary site away from the primary office and are considered extensions of that office and are not separate entities. The physical setting must be appropriate so that all elements of the checkup or treatment can be completed. The checkup must meet the requirements detailed in Subsection 4.5, “Parental Accompaniment” in Appendix D, Texas Health Steps Statutory State Requirements, of this handbook. The provider with a mobile unit or who uses portable dental equipment must obtain a permit for the mobile unit from the TSBDE.

5.2.4 Doctor of Dentistry Practicing as a Limited Physician
Dentists who serve clients and bill using medical (Current Procedural Terminology [CPT]) codes, such as oral-maxillofacial surgeons, may enroll as a doctor of dentistry practicing as a limited physician. Providers may enroll as an individual dentist or as a dental group. To enroll as a doctor of dentistry practicing as a limited physician, a dentist must:

- Be currently licensed by the TSBDE or currently licensed in the state where the service was performed.
- Have a Medicare provider identification number before applying for a Medicaid provider identifier.
- Enroll as a Medicaid provider with a limited physician provider identifier.

5.2.5 Medicaid Managed Care Enrollment
THSteps, ICF-MR, and emergency dental service providers do not need to enroll in Medicaid managed care. All claims for services provided by a dentist for THSteps and ICF-MR clients are submitted to TMHP.

If a client is enrolled in Medicaid managed care, the dentist must request precertification or approval from the client’s managed care organization (MCO) for general anesthesia and facility use charges if the dental services are to be provided in an ambulatory surgical center (ASC) a hospital ambulatory surgical center (HASC), or as an inpatient or outpatient at a hospital. The dentist must use the MCO’s contracted
facility and anesthesia provider. These services are included in the capitation rates paid to MCOs, and the facility/anesthesiologist risks nonpayment from the MCO without such prior approval. Coordination of all specialty care is the responsibility of the client’s primary care provider. The primary care provider must be notified by the dentist or the MCO of the planned services.

5.2.6 Client Rights
Dental providers enrolled in Texas Medicaid enter into a written contract with the HHSC to uphold the following rights of the Medicaid client:

- To receive dental services that meet or exceed the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- To receive information following a dental examination about the dental diagnosis; scope of proposed treatment, including alternatives and risks; anticipated results; and the need and risks for administration of sedation or anesthesia.
- To have full participation in the development of the treatment plan and the process of giving informed consent.
- To have freedom from physical, mental, emotional, sexual, or verbal abuse or harm from the provider or staff.
- To have freedom from overly aggressive treatment in excess of that required to address documented medical necessity.

A provider’s failure to ensure any of the client rights may result in termination of the provider agreement or contract and other civil or criminal remedies.

5.2.7 Complaints and Resolution
Complaints regarding dental services are typically received through the TMHP Contact Center, although a complaint is accepted from any source. A complaint is researched by TMHP and resolved or escalated as appropriate. Examples of complaints from clients regarding providers include:

- The provider did not consult with the client, explain what services were necessary, or obtain parent or guardian informed consent.
- The treating provider refused to make the child’s record available to the new provider.
- The provider did not give the child the appropriate local anesthesia or pain medication.
- The provider did not use sterile procedures; the facility or equipment were not clean.
- The provider or his staff were verbally abusive.
- The client did not receive a service, but the provider billed Texas Medicaid.
- The provider charged a Medicaid client for benefits covered by Medicaid.

5.3 Services/Benefits, Limitations, and Prior Authorization

5.3.1 THSteps Dental Services
THSteps is the Texas version of the Medicaid program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

THSteps dental services are mandated by Medicaid to provide for the early detection and treatment of dental health problems for Medicaid-eligible clients from birth through 20 years of age. THSteps dental service standards are designed to meet federal regulations and incorporate the recommendations of representatives of national and state dental professional organizations.
5.3.1 THSteps’ designated staff (Texas Department of State Health Services [DSHS], Department of Assistive and Disability Services [DADS], or contractor), through outreach and informing, encourage eligible children to use THSteps dental checkups and services when children first become eligible for Medicaid, and each time children are periodically due for their next dental checkup.

Children within Medicaid have free choice of Medicaid-enrolled providers and are given names of enrolled providers. A list of THSteps dental providers in a specific area can be obtained using the Online Provider Lookup on the TMHP website at www.tmhp.com, or by calling 1-877-847-8377.

Upon a provider’s request, DSHS (or its contractor) will assist eligible children with the scheduling of free transportation to their dental appointment or clients can call the Medical Transportation Program at 1-877-633-8747.

Refer to: Appendix E, Medical Transportation (Vol. 1, General Information) for information about transportation arrangements.

5.3.1.1 Parental Accompaniment

Children 14 years of age or younger must be accompanied to THSteps dental appointments by a parent, legal guardian, or another adult who is authorized by the parent or guardian unless the services are provided by an exempt entity as defined by the Human Resources Code. For additional information and exceptions, see subsection 4.5, “Parental Accompaniment” in Appendix D, Texas Health Steps Statutory State Requirements, in this handbook.

5.3.2 Comprehensive Care Program (CCP)

The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which federal financial participation (FFP) is available, regardless of the limitations of Texas Medicaid. This expansion is referred to as the Comprehensive Care Program (CCP).

CCP services are provided only for those clients who are birth through 20 years of age who are eligible to receive THSteps services. Dental services that are a benefit through CCP are designated in the Limitations column of the Medicaid dental fee schedules beginning in subsection 5.3.11, “Diagnostic Services” of this handbook, with the notation “CCP.”

5.3.3 ICF-MR Dental Services

ICF-MR dental services are mandated by Medicaid. Reimbursement is provided for treatment of dental problems for Medicaid-eligible residents of ICF-MR facilities who are 21 years of age or older. Residents of ICF-MR facilities who are 20 years of age or younger receive services through the regular THSteps Program. Eligibility for ICF-MR services is determined by DADS.

Procedure codes that do not have a CCP designation in the Limitations column of the dental fee schedule may be billed in a routine manner for ICF-MR clients. These procedures must be documented as medically necessary and appropriate. ICF-MR clients are not subject to periodicity for preventive care. For procedure codes that have a CCP designation, a provider may request authorization with documentation or provide documentation on the submitted claim.

Refer to: Subsection 5.3.10, “Medicaid Dental Benefits, Limitations, and Fee Schedule” of this handbook.

5.3.3.1 THSteps and ICF-MR Provision of Dental Services

All THSteps and ICF-MR dental services must be performed by the Medicaid-enrolled dental provider except for permissible work that is delegated to a licensed dental hygienist, dental assistant, or dental technician in a dental laboratory on the premises where the dentist practices, or in a commercial laboratory registered with the Texas State Board of Dental Examiners (TSBDE). The Texas Dental
Practice Act and the rules and regulations of the TSBDE (22 TAC, Part 5) define the scope of work that dental auxiliary personnel may perform. Any deviations from these practice limitations shall be reported to the TSBDE and HHSC, and could result in sanctions or other actions imposed against the provider.

THSteps and ICF-MR clients must receive:

- Dental services specified in the treatment plan that meet the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- Dental services free from abuse or harm from the provider or the provider’s staff.
- Only the treatment required to address documented medical necessity that meets professionally recognized standards of health care.

5.3.3.2 Children in Foster Care

Clients in foster care receive services from Superior HealthPlan StarDent Dental Services (StarDent). The general information telephone number for Superior HealthPlan is 1-866-439-2042.

For dental procedures that require prior authorization, providers should call StarDent at 1-866-708-8795. The fax number is 1-281-313-7154.

5.3.4 Written Informed Consent and Standards of Care

Only THSteps clients or their parents or legal guardians can give written informed consent for dental services. Written consent must be given within the 1-year period prior to the date the services are provided, and must not have been revoked. THSteps clients or their parents or legal guardians who can give written informed consent must receive information following a dental examination about the dental diagnosis, scope of proposed treatment, including alternatives and risks, anticipated results, and need for and risks of the administration of sedation or anesthesia. Additionally, they must receive a full explanation of the treatment plan and give written informed consent before treatment is initiated. The parent or guardian being present at the time of the dental visit facilitates the provider obtaining written informed consent. Dentists must comply with TSBDE Rule 22 TAC §108.2, “Fair Dealing.”

5.3.5 First Dental Home

Based on the American Academy of Pediatric Dentistry’s (AAPD) definition, Texas Medicaid defines a dental home as the dental provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a client’s dental home begins no later than 6 months of age and includes referrals to dental specialists when appropriate.

In providing a dental home for a client, the dental provider enhances the ability to assist clients and their parents in obtaining optimum oral health care. The first dental home visit can be initiated as early as 6 months of age and must include, but is not limited to, the following:

- Comprehensive oral examination
- Oral hygiene instruction with primary caregiver
- Dental prophylaxis, if appropriate
- Topical fluoride varnish application when teeth are present
- Caries risk assessment
- Dental anticipatory guidance

Clients from 6 months of age through 35 months of age may be seen for dental checkups by a certified First Dental Home provider.
First Dental Home services are billed using procedure code D0145. The dental home provider must retain supporting documentation for procedure code D0145 in the client's record. The supporting documentation must include, but is not limited to, the following:

- Oral and physical health history review
- Dental history review
- Primary caregiver’s oral health
- Oral evaluation
- Caries risk assessment
- Dental prophylaxis, which may include a toothbrush prophylaxis
- Oral hygiene instruction with parent/caregiver
- Fluoride varnish application
- An appropriate preventive oral health regimen (recall schedule)
- Anticipatory guidance communicated to the client’s parent, legal guardian, or primary caregiver to include the following:
  - Oral health and home care
  - Oral health of primary caregiver/other family members
  - Development of mouth and teeth
  - Oral habits
  - Diet, nutrition, and food choices
  - Fluoride needs
  - Injury prevention
  - Medications and oral health
  - Any referrals, including dental specialist’s name

Procedure code D0145 is limited to individual dentists certified by the DSHS Oral Health Program to perform this service.

Procedure codes D0120, D0150, D0160, D0170, D0180, D1120, D1203, D1206, and D8660 are denied if procedure code D0145 is billed on the same date of service (DOS) by any provider. A First Dental Home examination is limited to ten services per client lifetime with at least 61 days between visits by any provider to prevent denials of the service.

### 5.3.6 Dental Referrals by THSteps Primary Care Providers

Dental providers may receive referrals for clients who are 6 months of age or older from THSteps primary care providers. The primary care provider must provide information about the initiation of routine dental services with the recommendation to the client’s parent or guardian that an appointment be scheduled with a dental provider in order to establish a dental home. If a THSteps dental checkup reveals a dental health condition that requires follow-up diagnosis or treatment, the provider performing the dental checkup should assist the client in planning follow-up care within their practice or in making a referral to another qualified dental provider.
If the client is enrolled in a Medicaid managed care health maintenance organization (HMO) for their medical care, the dental care will be provided by Texas Medicaid fee-for-service THSteps dental providers. However, other providers, such as the facility and anesthesiology care, must be HMO network providers. Facility and anesthesiology services must be pre-approved by the HMO.

**Note:** Clients who are 20 years of age or younger may refer themselves for dental services.

### 5.3.7 Change of Provider

A provider may refer a client to another dental provider for treatment for any of the following reasons:

- Treatment by a dental specialist such as a pediatric dentist, periodontist, oral surgeon, endodontist, or orthodontist is indicated and is in the best interests of the THSteps client.
- The services needed are outside the skills or scope of practice of the initial provider.

A provider may discontinue treatment if there is documented failure to keep appointments by the client, noncompliance with the treatment plan, or conflicts with the client or other family members. In any such action to discontinue treatment, providers must comply with 22 TAC §108.5, “Patient Abandonment.”

The client also may select another provider, if desired. HHSC may refer the client to another provider as a result of adverse information obtained during a utilization review or resolution of a complaint from either provider or client.

#### 5.3.7.1 Interrupted or Incomplete Orthodontic Treatment Plans

Authorizations for orthodontic or extensive restorative treatment plans that have been prior authorized for a provider are not transferable to another provider. If a client’s treatment plan is interrupted and the services are not completed, the new provider must request prior authorization to complete the interrupted, incomplete, and prior authorized treatment plan initiated by the original provider.

To complete the treatment plan, the client must be eligible for Medicaid with a current client Medicaid Identification Form (Form H3087) or Medicaid Eligibility Verification Form (Form H1027).

If the client does not return for the completion of services and there is a documented failure to keep appointments by the client, the dental provider who initiated the services may submit a claim for reimbursement in compliance with the 95-day filing deadline.

**Refer to:** Subsection 5.3.24.4, “Transfer of Orthodontic Services” in this handbook.

### 5.3.8 Periodicity for THSteps Dental Services

For clients who are 6 months of age through 20 years of age, dental checkups may occur at 6-month (181-day) intervals. Texas Medicaid has adopted the AAPD’s “Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children” to serve as a guide and reference for dentists when scheduling and providing services to THSteps clients.

In November 2004, the American Dental Association (ADA), in conjunction with the U.S. Food and Drug Administration, established “Guidelines for Prescribing Dental Radiographs.” The guidelines include type of encounters relevant to the client’s age and dental developmental stage. Texas Medicaid has adopted the ADA guidelines to serve as a guide and reference for dentists who treat THSteps clients.

**Refer to:** Subsection G.1, “American Academy of Pediatric Dentistry Periodicity Guidelines (9 Pages)” and subsection G.2, “American Dental Association Guidelines for Prescribing Dental Radiographs (3 Pages)” in this handbook.

THSteps dental providers may provide any medically necessary dental services such as emergency, diagnostic, preventive, therapeutic, and orthodontic services that are within the Texas Medicaid guidelines and limitations specified for each area as long as the client’s Medicaid eligibility is current for the date that dental services are being provided.
5.3.8.1 Exceptions to Periodicity

If a periodic dental checkup has been conducted within the last six months, the client still may be able to receive another periodic dental checkup in the same six-month period by any provider. For THSteps clients, exceptions to the six-month periodicity schedule for dental checkup services may be approved for one of the following reasons:

- Medically necessary service, based on risk factors and health needs (includes clients from birth through 6 months of age).
- Required to meet federal or state exam requirements for Head Start, daycare, foster care, preadoption, or to provide a checkup prior to the next periodically-due checkup if the client will not be available when due. This includes clients whose parents are migrant or seasonal workers.
- Clients’ choice to request a second opinion or change service providers (not applicable to referrals).
- Subsequent therapeutic services necessary to complete a case for clients who are 5 months of age or younger when initiated as emergency services, for trauma, or early childhood caries.
- Medical checkup prior to a dental procedure requiring general anesthesia.
- A First Dental Home client can be seen up to 10 times within the age of 6-months through 35-months.

The provider should determine if the client is Medicaid-eligible for the date that dental services are to be provided. If the client’s Medicaid Identification Form (Form H3087) indicates that the client is eligible for dental services, the client is requesting a periodic dental checkup, and the provider’s records indicate that they have provided a periodic checkup within the current six-month (181-day) interval, the provider may not provide a second periodic checkup unless the provider can document medical necessity for the second periodic checkup. However, the provider may still provide any other necessary dental services that are a benefit.

When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the client’s file and on the claim submission. For claims filed electronically, check “yes” when prompted. For claims filed on paper, place comments in Block 35.

For ICF-MR clients 21 years of age or older, the periodicity schedule for preventive dental procedures (exams, prophylaxis, fluoride, and radiographs) does not apply.
5.3.9 Tooth Identification (TID) and Surface Identification (SID) Systems

Claims are denied if the procedure code is not compatible with TID and/or SID. Use the alpha characters to describe tooth surfaces or any combination of surfaces. For SID designation on anterior teeth, use facial (F) and incisal (I). For SID purposes, use buccal (B) and occlusal (O) designations for posterior teeth.

<table>
<thead>
<tr>
<th>SID</th>
<th>SID</th>
<th>SID</th>
<th>SID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buccal</td>
<td>DB</td>
<td>DFI</td>
<td>DLI</td>
</tr>
<tr>
<td>Distal</td>
<td>DF</td>
<td>DFL</td>
<td>DOLB</td>
</tr>
<tr>
<td>Facial</td>
<td>DI</td>
<td>DFM</td>
<td>MIDF</td>
</tr>
<tr>
<td>Incisal</td>
<td>DL</td>
<td>DIL</td>
<td>MIDL</td>
</tr>
<tr>
<td>Lingual</td>
<td>DO</td>
<td>DLB</td>
<td>MIDLF</td>
</tr>
<tr>
<td>Mesial</td>
<td>IL</td>
<td>DLM</td>
<td>MIFL</td>
</tr>
<tr>
<td>Occlusal</td>
<td>MB</td>
<td>DOB</td>
<td>MLBD</td>
</tr>
<tr>
<td></td>
<td>MI</td>
<td>DOL</td>
<td>MLDF</td>
</tr>
<tr>
<td></td>
<td>ML</td>
<td>ILF</td>
<td>MODB</td>
</tr>
<tr>
<td></td>
<td>MO</td>
<td>MBD</td>
<td>MODL</td>
</tr>
<tr>
<td></td>
<td>OB</td>
<td>MID</td>
<td>MODLB</td>
</tr>
<tr>
<td></td>
<td>OL</td>
<td>MIF</td>
<td>MOLB</td>
</tr>
</tbody>
</table>

5.3.9.1 Supernumerary Tooth Identification

Each identified permanent tooth and each identified primary tooth has its own identifiable supernumerary number. This developed system can be found in the CDT published by the ADA.

The TID for each identified supernumerary tooth will be used for paper and electronic claims and can only be billed with the following procedure codes:

- For primary teeth only: D7111.
- For both primary and permanent teeth the following codes are billable: D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7285, D7286, and D7510.

<table>
<thead>
<tr>
<th>Permanent Teeth Upper Arch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tooth #</td>
</tr>
<tr>
<td>Super #</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Permanent Teeth Lower Arch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tooth #</td>
</tr>
<tr>
<td>Super #</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Teeth Upper Arch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tooth #</td>
</tr>
<tr>
<td>Super #</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Teeth Lower Arch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tooth #</td>
</tr>
<tr>
<td>Super #</td>
</tr>
</tbody>
</table>
5.3.10 Medicaid Dental Benefits, Limitations, and Fee Schedule

For THSteps clients, dental procedure limitations may be waived when all the following have been met. The dental procedure is:

- Medically necessary and FFP is available for it.
- Prior authorized by the TMHP Dental Director.
- Properly documented in the client’s record (refer to subsection 5.4, “Documentation Requirements” in this handbook).

For ICF-MR clients, services designated as CCP-type are available. In the Limitations column of the fee schedule, abbreviations indicate the age range limitations and documentation requirements. The following abbreviations also appear in a table at the bottom of each page of the fee schedule:

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Age range limitations</td>
</tr>
<tr>
<td>CCP</td>
<td>Payable under CCP for clients 20 years of age or younger when THSteps benefits or limits are exceeded</td>
</tr>
<tr>
<td>DOS</td>
<td>Date of service</td>
</tr>
<tr>
<td>FMX</td>
<td>Intraoral radiographs—complete series</td>
</tr>
<tr>
<td>MTID</td>
<td>Missing tooth ID(s)</td>
</tr>
<tr>
<td>N</td>
<td>Narrative of medical necessity for the procedure must be retained in the client’s record</td>
</tr>
<tr>
<td>NC</td>
<td>Not reimbursed by Medicaid. Services may not be charged to the client.</td>
</tr>
<tr>
<td>PATH</td>
<td>Pathology report must accompany the claim and must be retained in the client’s record</td>
</tr>
<tr>
<td>PC</td>
<td>Periodontal charting must be retained in the client’s record</td>
</tr>
<tr>
<td>PHO</td>
<td>Preoperative and postoperative photographs required and must be maintained in the client’s medical record</td>
</tr>
<tr>
<td>PPXR</td>
<td>Preoperative and postoperative radiographs are required when the procedure is performed and must be retained in the client’s record; do not send with initial claims</td>
</tr>
<tr>
<td>PXR</td>
<td>Preoperative radiographs are required when the procedure is performed and must be retained in the client’s record; do not send with initial claims</td>
</tr>
</tbody>
</table>

5.3.11 Diagnostic Services

Diagnostic services should be performed for all clients, starting within the first 6 months of the eruption of the first primary tooth, but no later than 1 year of age.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Oral Evaluations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Procedure codes D0140, D0160, D0170, and D0180 are limited dental codes and may be paid in addition to a comprehensive oral exam (procedure code D0150) or periodic oral exam (procedure code D0120), when billed within a 6 month period. When submitting a claim for procedure code D0140, D0160, D0170, or D0180, the provider must indicate documentation of medical necessity on the claim. These claims are subject to retrospective review. If no comments are indicated on the claim form, the payment may be recouped.

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120*</td>
<td>A Birth-20. Limited to 1 every 6 months by the same provider. Denied when billed on the same DOS as D0145.</td>
<td>$29.44</td>
</tr>
<tr>
<td>D0140*</td>
<td>Used for problem focused examination of a specific tooth or area of the mouth. Limited to one service per day by the same provider or to two services per day by different providers. Denied when billed on the same DOS as D0160 by the same provider. A Birth-20, N</td>
<td>$19.16</td>
</tr>
<tr>
<td>D0145*</td>
<td>Limited to one service a day and 10 times a lifetime, with a minimum of 60 days between dates of service. Providers must be certified by DSHS Oral Health Program staff to perform this procedure. Procedure codes D0120, D0150, D0160, D0170, D0180, D8660, D1120, D1203, or D1206 will be denied when billed by any provider on the same DOS. A 6-35 months</td>
<td>$144.97</td>
</tr>
<tr>
<td>D0150*</td>
<td>Used for problem focused reevaluation. Limited to 1 every 3 years by the same provider. Denied when billed on the same DOS as D0145. A Birth-20</td>
<td>$36.04</td>
</tr>
<tr>
<td>D0160*</td>
<td>Used for problem focused reevaluation. Limited to one service per day by the same provider. Not payable for routine postoperative follow-up. Denied when billed on the same DOS as D0145. A 1-20, N, CCP</td>
<td>$15.25</td>
</tr>
<tr>
<td>D0170*</td>
<td>Limited to one service per day by the same provider. When used for emergency claims, refer to General Information. Denied when billed on the same DOS as procedure code D0140 or D0160 for the same provider. Denied when billed on the same DOS as D0145. A Birth-20</td>
<td>$16.88</td>
</tr>
<tr>
<td>D0180*</td>
<td>Used for periodontal evaluation. Denied when billed for the same DOS as D0120, D0140, D0145, D0150, D0160 or D0170 by the same provider. A 13-20</td>
<td>$8.02</td>
</tr>
</tbody>
</table>

The provider must document medical necessity and the specific tooth or area of the mouth on the claim for procedure codes D0140, D0160, and D0170.

Documentation supporting medical necessity for procedure codes D0140, D0160, and D0170 must also be maintained by the provider in the client’s medical record and must include the following:

- The client complaint supporting medical necessity for the examination
- The specific area of the mouth that was examined or the tooth involved
- A description of what was done during the visit
- Supporting documentation of medical necessity which may include, but is not limited to, radiographs or photographs

Documentation supporting medical necessity for procedure code D0180 must be maintained by the provider in the client’s medical record and must include the following:

- The client complaint supporting medical necessity for the examination
- A description of what was done during the treatment
- Supporting documentation of medical necessity which may include, but is not limited to, radiographs or photographs

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0210</td>
<td>Limited to 1 service every 3 years by the same provider. Not allowed as an emergency service. A 2-20</td>
<td>$72.08</td>
</tr>
<tr>
<td>D0220</td>
<td>Limited to one service a day by the same provider. A 1-20</td>
<td>$12.82</td>
</tr>
<tr>
<td>D0230</td>
<td>The total cost of periapicals and/or other radiographs cannot exceed the payment for a complete intraoral series. A 1-20</td>
<td>$11.74</td>
</tr>
<tr>
<td>D0240</td>
<td>Limited to 2 services per day by the same provider. Periapical films taken at an occlusal angle should be billed as periapical radiograph, procedure code D0230. May be billed as an emergency service. A Birth-20</td>
<td>$10.00</td>
</tr>
<tr>
<td>D0250</td>
<td>Limited to one service a day by the same provider. A 1-20, N, CCP</td>
<td>$18.75</td>
</tr>
<tr>
<td>D0260</td>
<td>A 1-20, N, CCP</td>
<td>$12.50</td>
</tr>
<tr>
<td>D0270</td>
<td>Limited to one service a day by the same provider. A 1-20</td>
<td>$5.00</td>
</tr>
<tr>
<td>D0272</td>
<td>Limited to one service a day by the same provider. A 1-20</td>
<td>$23.86</td>
</tr>
<tr>
<td>D0273</td>
<td>Limited to one service a day by the same provider. A 1-20</td>
<td>$29.60</td>
</tr>
<tr>
<td>D0274</td>
<td>Limited to one service a day by the same provider. A 2-20</td>
<td>$35.32</td>
</tr>
<tr>
<td>D0277</td>
<td>Limited to one service a day by the same provider. Not to be billed within 36 months of D0210 or D0330. A 2-20</td>
<td>$31.75</td>
</tr>
<tr>
<td>D0290</td>
<td>A 1-20, N, CCP</td>
<td>$33.75</td>
</tr>
<tr>
<td>D0310</td>
<td>A 1-20, N, CCP</td>
<td>$45.00</td>
</tr>
<tr>
<td>D0320</td>
<td>A 1-20, N, CCP</td>
<td>$75.00</td>
</tr>
<tr>
<td>D0321</td>
<td>A 1-20, N, CCP</td>
<td>$35.00</td>
</tr>
<tr>
<td>D0322</td>
<td>A 1-20, N, CCP</td>
<td>$33.75</td>
</tr>
<tr>
<td>D0330*</td>
<td>Limited to one service a day, any provider and to one service every 3 years by the same provider. Not allowed on emergency claims unless third molars or a traumatic condition is involved. 2 years of age or younger, must document the necessity of a panoramic film. The Panorex (D0330) with four bitewing radiographs (D0274) may be considered equivalent to the complete or full-mouth series (D0210), and the billed amount for either combination is equivalent to the maximum fee of $72.08. A 3-20</td>
<td>$65.08</td>
</tr>
<tr>
<td>D0340*</td>
<td>Limited to one service a day by the same provider. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A 1-20, N, CCP</td>
<td>$33.75</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
Procedure Code | Limitations                                                                 | Maximum Fee |
---------------|-------------------------------------------------------------------------------|-------------|
D0350*        | Limited to one service a day by the same provider. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A Birth-20 | $18.75      |
D0360*        | Prior authorization is required. Limited to a combined maximum of 3 services per year (with procedure codes D0362 and D0363), any provider. Additional services may be considered with documentation of medical necessity. A Birth-20 | $288.75     |
D0362*        | Prior authorization is required. Limited to a combined maximum of 3 services per year (with procedure codes D0360 and D0363), any provider. Additional services may be considered with documentation of medical necessity. A Birth-20 | $173.25     |
D0363*        | Prior authorization is required. Limited to a combined maximum of 3 services per year (with procedure codes D0360 and D0362), any provider. Additional services may be considered with documentation of medical necessity. A Birth-20 | $231.00     |

Note: Radiograph codes do not include the exam. If an exam is also performed, providers must bill the appropriate ADA procedure code.

Procedure Code D0350 must be used for billing for photographs, and will be accepted only when diagnostic-quality radiographs cannot be taken. Supporting documentation and photographs must be maintained in the client’s medical record when medical necessity is not evident on radiographs for dental caries or the following procedure codes. Medical necessity must be documented on the electronic or paper claim.

Procedure Codes

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4211</td>
<td></td>
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<td>D4240</td>
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<td>D4241</td>
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<tr>
<td>D4245</td>
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<tr>
<td>D4266</td>
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<td>D4267</td>
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<td>D4270</td>
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<td>D4271</td>
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<tr>
<td>D4273</td>
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</tbody>
</table>

Procedure Codes

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0415</td>
<td>A 1-20, N, CCP</td>
<td>$25.00</td>
</tr>
<tr>
<td>D0425</td>
<td>Not reimbursable separately. Considered part of another dental procedure.</td>
<td>NC</td>
</tr>
<tr>
<td>D0460</td>
<td>Limited to one service a day by the same provider. Not payable for primary teeth. Will deny when billed on the same DOS as any endodontic procedure. A 1-20, N, CCP</td>
<td>$12.50</td>
</tr>
<tr>
<td>D0470*</td>
<td>Not reimbursable separately when crown, fixed prosthodontics, diagnostic workup, or crossbite therapy workup is performed. A 1-20, N, CCP</td>
<td>$22.50</td>
</tr>
</tbody>
</table>

Note: Radiograph codes do not include the exam. If an exam is also performed, providers must bill the appropriate ADA procedure code.

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
### Oral Pathology Laboratory

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0472</td>
<td>By pathology laboratories only. (refer to CPT codes)</td>
<td>NC</td>
</tr>
<tr>
<td>D0473</td>
<td>By pathology laboratories only. (refer to CPT codes)</td>
<td>NC</td>
</tr>
<tr>
<td>D0474</td>
<td>By pathology laboratories only. (refer to CPT codes)</td>
<td>NC</td>
</tr>
<tr>
<td>D0480</td>
<td>By pathology laboratories only. (refer to CPT codes)</td>
<td>NC</td>
</tr>
<tr>
<td>D0502</td>
<td>A 1-20, N, CCP</td>
<td>$57.50</td>
</tr>
<tr>
<td>D0999</td>
<td>A 1-20, N, CCP</td>
<td>Manually priced</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.

### 5.3.12 Preventive Services

#### Dental Prophylaxis

If performing fluoride treatments, procedure codes D1203 and D1204 must be submitted on the same DOS as the cleaning (D1110 and D1120).

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110*</td>
<td>Limited to one prophylaxis per client per 6-month period (includes oral health instructions). If billed on emergency claim, procedure code will be denied. Denied when billed on the same DOS as any D4000 series periodontal procedure code. A 13-20</td>
<td>$56.00</td>
</tr>
<tr>
<td>D1120*</td>
<td>Limited to one prophylaxis per client per 6-month period (includes oral health instructions). If billed on emergency claim, procedure code will be denied. Denied when billed on the same DOS as any D4000 series periodontal procedure code, or with procedure code D0145. A 6 months - 12 years</td>
<td>$37.50</td>
</tr>
</tbody>
</table>

#### Topical Fluoride Treatment (Office Procedure)

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1203*</td>
<td>Includes oral health instructions. Denied when billed on the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. A 6 months - 12 years, N, CCP</td>
<td>$15.00</td>
</tr>
<tr>
<td>D1204*</td>
<td>Includes oral health instructions. Denied when billed on the same DOS as any D4000 series periodontal procedure code. A 13-20, N, CCP</td>
<td>$15.00</td>
</tr>
<tr>
<td>D1206</td>
<td>Includes oral health instructions. Denied when billed on the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. A 6 months-20 years, N, CCP</td>
<td>$15.00</td>
</tr>
</tbody>
</table>

#### Other Preventive Services

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1310</td>
<td>Denied as part of all preventative, therapeutic and diagnostic dental procedures. A client requiring more involved nutrition counseling may be referred to a THSteps primary care physician.</td>
<td>NC</td>
</tr>
<tr>
<td>D1320</td>
<td>A client requiring tobacco counseling may be referred to a THSteps primary care provider.</td>
<td>NC</td>
</tr>
<tr>
<td>D1330</td>
<td>Requires documentation of the type of instructions, number of appointments, and content of instructions. This procedure refers to services above and beyond routine brushing and flossing instruction and requires that additional time and expertise have been directed toward the client’s care. Denied when billed on the same day as dental prophylaxis (D1110, D1120) and/or topical fluoride treatments (D1203, D1204, and D1206) by the same provider. Limited to once per client, per year by any provider. A 1-20, N, CCP</td>
<td>$12.50</td>
</tr>
<tr>
<td>D1351*</td>
<td>Sealants may be applied to the occlusal, buccal, and lingual pits and fissures of any tooth that is at risk for dental decay and is free of proximal caries and free of restorations on the surface to be sealed. Sealants are a benefit when applied to deciduous (baby or primary) teeth or permanent teeth. Indicate the tooth numbers and surfaces on the claim form. Reimbursement will be considered on a per-tooth basis, regardless of the number of surfaces sealed. Denied when billed on the same DOS as any D4000 series periodontal procedure code. Sealants and replacement sealants are limited to one every 3 years per tooth by any provider. A 1-20</td>
<td>$28.82</td>
</tr>
</tbody>
</table>

**Space Maintenance (Passive Appliances)**

When a client needs a space maintainer and exceeds the listed age limitation, the service can be a benefit under CCP. The provider must justify medical necessity with radiograph(s) and/or a narrative on the prior authorization request and receive prior authorization for consideration of payment of the service.

Limitation for space maintainers is to hold the space for the loss of one of the first or second primary molars (TIDs #A, B, I, J, K, L, S, and T) or the loss of a permanent first molar (TIDs #3, 14, 19, and 30). Fees for space maintainers include maintenance and repair. One space maintainer is reimbursed per TID, per client, per lifetime. When procedure code D1510 or D1515 have been previously reimbursed, the recementation of space maintainers may be considered for reimbursement to either the same or different THSteps dental provider when billed with procedure code D1550. Replacement space maintainers may be considered upon appeal with documentation supporting medical necessity. Removal of a fixed space maintainer is not payable to the provider or dental group practice that originally placed the device.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1510*</td>
<td>A 1-20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1-20 (TIDs #3, 14, 19, 30), MTID</td>
<td>$160.00</td>
</tr>
<tr>
<td>D1520*</td>
<td>A 1-20 (TIDs #A, B, I, J, K, L, S, T), MTID A 1-20 (TIDs #3, 14, 19, 30), MTID</td>
<td>$75.00</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, *= Services payable to an FQHC for a client encounter.
5.3.13 Therapeutic Services

Medicaid reimbursement is contingent on compliance with the following limitations:

- For documentation requirements, refer to subsection 5.4, “Documentation Requirements” in this handbook.
- Total restorative fee per tooth on primary teeth cannot exceed $156.06, which is the fee for a stainless steel crown (exceptions: D2335 and D2933).
- All fees for tooth restorations include local anesthesia and pulp protective media, where indicated, without additional charges. These services are considered part of the restoration.
- More than one restoration on a single surface is considered a single restoration.
- Multiple surface restorations must show definite crossing of the plane of each surface listed for each primary and permanent tooth completed.
- A multiple surface restoration cannot be billed as two or more separate one-surface restorations.
- Restorations and therapeutic care are provided as a Medicaid service based on medical necessity and reimbursed only for therapeutic reasons and not preventive purposes (refer to CDT).

All dental restorations and prosthetic appliances that require lab fabrication may be submitted for reimbursement using the date the final impression was made as the DOS. If the client did not return for final seating of the restoration or appliance, a narrative must be included on the claim form and in the client’s chart in lieu of a postoperative radiograph. The 95-day filing deadline is in effect from the date of the final impression. If the client returns to the office after the claim has been filed, the dentist is obligated to attempt to seat the restoration or appliance at no cost to the client or Texas Medicaid. For records retention requirements, refer to Subsection 5.4, “Documentation Requirements” in this handbook.

Direct pulp caps may be reimbursed separately from any final tooth restoration performed on the same tooth (as noted by the TID) on the same DOS by the same provider.
## 5.3.14 Restorative Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amalgam Restorations (Including Polishing)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2140*</td>
<td>Reimburse primary TIDs #A-T at $61.98; reimburse permanent TIDs #1-5, 12-21, and 28-32 at $65.72. A Birth-20, PXR</td>
<td>$65.72</td>
</tr>
<tr>
<td>D2150*</td>
<td>Reimburse primary TIDs #A-T at $82.90; reimburse permanent TIDs #1-5, 12-21, and 28-32 at $87.46. A Birth-20, PXR</td>
<td>$87.46</td>
</tr>
<tr>
<td>D2160*</td>
<td>Reimburse primary TIDs #A-T at $90.01; reimburse permanent TIDs #1-5, 12-21, and 28-32 at $111.42. A 1-20, PXR</td>
<td>$111.42</td>
</tr>
<tr>
<td>D2161*</td>
<td>Reimburse primary TIDs #A-T at $52.69; reimburse permanent TIDs #1-5, 12-21, and 28-32 at $60.04. A 1-20, PXR</td>
<td>$60.04</td>
</tr>
<tr>
<td><strong>Resin-Based Composite Restorations—Direct</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All fees for resin restorations on primary teeth are limited to $156.06, which is the fee for a stainless steel crown (exceptions: D2335 and D2933). All fees for resin restorations on permanent teeth are limited to a total of $170.38 for posterior teeth and $170.38 for anterior teeth. Resin restoration includes composites or glass ionomer.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2330*</td>
<td>TID #C-H, M-R, 6-11, 22-27. A Birth-20, PXR</td>
<td>$79.34</td>
</tr>
<tr>
<td>D2331*</td>
<td>TID #C-H, M-R, 6-11, 22-27. A Birth-20, PXR</td>
<td>$105.14</td>
</tr>
<tr>
<td>D2332*</td>
<td>TID #C-H, M-R, 6-11, 22-27. A 1-20, PXR</td>
<td>$137.28</td>
</tr>
<tr>
<td>D2390*</td>
<td>Reimburse primary anterior TIDs #C-H, M-R at $68.75; reimburse permanent anterior TIDs #6-11, 22-27 at $150.00. A Birth-20, PXR</td>
<td>$150.00</td>
</tr>
<tr>
<td>D2391*</td>
<td>Reimburse primary posterior TIDs #A, I, J, K, L, S, T at $76.98; reimburse permanent posterior TIDs #1-5, 12-21, 28-32 at $84.08. A Birth-20, PXR</td>
<td>$84.08</td>
</tr>
<tr>
<td>D2392*</td>
<td>Reimburse primary posterior TIDs #A, I, J, K, L, S, T at $98.98; reimburse permanent posterior TIDs #1-5, 12-21, 28-32 at $110.20. A Birth-20, PXR</td>
<td>$110.20</td>
</tr>
<tr>
<td>D2393*</td>
<td>Reimburse primary posterior TIDs #A, I, J, K, L, S, T at $87.11; reimburse permanent posterior TIDs #1-5, 12-21, 28-32 at $101.18. A 1-20, PXR</td>
<td>$101.18</td>
</tr>
<tr>
<td>D2394*</td>
<td>Reimburse primary posterior TIDs #A, I, J, K, L, S, T at $64.62; reimburse permanent posterior TIDs #1-5, 12-21, 28-32 at $75.06. A 1-20, PXR</td>
<td>$75.06</td>
</tr>
<tr>
<td><strong>Gold Foil Restorations (Permanent Teeth only)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2410</td>
<td>A 13-20, N, PPXR, CCP</td>
<td>$75.00</td>
</tr>
<tr>
<td>D2420</td>
<td>A 13-20, N, PPXR, CCP</td>
<td>$125.00</td>
</tr>
<tr>
<td>D2430</td>
<td>A 13-20, N, PPXR, CCP</td>
<td>$125.00</td>
</tr>
<tr>
<td><strong>Inlay/Onlay Restorations (Permanent Teeth only)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All fees for inlay/onlay restorations on permanent teeth are limited to $170.38 for posterior teeth and $170.38 for anterior teeth. Inlay/onlay includes all metal inlays/onlays.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2510</td>
<td>A 13-20, N, PPXR, CCP</td>
<td>$181.25</td>
</tr>
<tr>
<td>D2520</td>
<td>A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2530</td>
<td>A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2542</td>
<td>Same as D2520. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2543</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2544</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2610</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2620</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2630</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2642</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2643</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2644</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2650</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2651</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2652</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2662</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2663</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2664</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
</tbody>
</table>

**Crows—Single Restorations Only**

For procedure codes D2710 through D2799, single crown restorations (permanent teeth only) the following limitations apply:

- Porcelain is allowed on all teeth.
- Prior authorization is required for any combination of inlays/onlays or permanent crowns that exceed the limit of four inlays/onlays or permanent crowns.

Stainless steel crowns and permanent all-metal cast crowns are not reimbursed on anterior permanent teeth (6-11, 22-27).

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2710</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2720</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2721</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2722</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2740</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2750*</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$528.00</td>
</tr>
<tr>
<td>D2751*</td>
<td>All materials accepted. A 13-20, N, PPXR</td>
<td>$528.00</td>
</tr>
<tr>
<td>D2752</td>
<td>All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$528.00</td>
</tr>
<tr>
<td>D2780</td>
<td>A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2781</td>
<td>A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2782</td>
<td>A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2783</td>
<td>Anterior teeth only (#6-11 and 22-27). A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2790</td>
<td>Posterior teeth only (#1-5, 12-21, and 28-32). All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$528.00</td>
</tr>
<tr>
<td>D2791*</td>
<td>Posterior teeth only (#1-5, 12-21, and 28-32). All materials accepted. A 13-20, N, PPXR</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2792*</td>
<td>Posterior teeth only (#1-5, 12-21, and 28-32). All materials accepted. A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2794</td>
<td>A 13-20, N, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D2799</td>
<td>Denied as global fee to any crown placed.</td>
<td>NC</td>
</tr>
</tbody>
</table>

**Other Restorative Services**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2910</td>
<td>A 13-20, PXR</td>
<td>$18.75</td>
</tr>
<tr>
<td>D2915</td>
<td>A 4-20</td>
<td>$18.75</td>
</tr>
<tr>
<td>D2920</td>
<td>A 1-20, PXR</td>
<td>$20.00</td>
</tr>
<tr>
<td>D2930*</td>
<td>A Birth-20, PXR</td>
<td>$156.06</td>
</tr>
<tr>
<td>D2931*</td>
<td>A 1-20, PXR</td>
<td>$162.50</td>
</tr>
<tr>
<td>D2932*</td>
<td>A 1-20, PXR (primary tooth)</td>
<td>$68.75</td>
</tr>
<tr>
<td>D2933*</td>
<td>Limited to anterior primary teeth only (TID #C-H, M-R). A Birth-20, N, CCP, PXR</td>
<td>$156.06</td>
</tr>
<tr>
<td>D2934*</td>
<td>Limited to anterior primary teeth only (TID #C-H, M-R). A Birth-20, N, CCP, PXR</td>
<td>$156.06</td>
</tr>
<tr>
<td>D2940*</td>
<td>Not allowed on the same date as permanent restoration. A Birth-20, PXR</td>
<td>$36.58</td>
</tr>
<tr>
<td>D2950*</td>
<td>Provider payments received in excess of $45.00 for restorative work performed within 6 months of a crown procedure on the same tooth will be deducted from the subsequent crown procedure reimbursement. Not allowed on primary teeth. A 4-20, N, CCP, PXR</td>
<td>$45.00</td>
</tr>
<tr>
<td>D2951</td>
<td>Not allowed on primary teeth. A 4-20, PXR</td>
<td>$12.50</td>
</tr>
<tr>
<td>D2952</td>
<td>Not payable with D2950. Not allowed on primary teeth. A 13-20, CCP, PXR</td>
<td>$87.50</td>
</tr>
<tr>
<td>D2953</td>
<td>Must be used with D2952. Not allowed on primary teeth. A 13-20</td>
<td>$43.75</td>
</tr>
<tr>
<td>D2954*</td>
<td>Not payable with D2952 or D3950 on the same TID by the same provider. Not allowed on primary teeth. A 13-20, N, CCP, PXR</td>
<td>$75.00</td>
</tr>
<tr>
<td>D2955</td>
<td>For removal of posts (for example, fractured posts) not to be used in conjunction with endodontic retreatment (D3346, D3347, D3348). Not allowed on primary teeth. A 4-20, CCP, PXR</td>
<td>$75.00</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
5.3.15 Endodontics Services

Therapeutic pulpotomy (procedure code D3220) and apexification and recalcification procedures (procedure codes D3310, D3320, and D3330) are considered part of the root canal (procedure codes D3346, D3347, and D3348). When therapeutic pulpotomy or apexification and recalcification procedures are billed with root canal codes, the reimbursement rate is adjusted to ensure that the total amount reimbursed does not exceed the total dollar amount allowed for the root canal procedure.

Reimbursement for a root canal includes all appointments necessary to complete the treatment. Pulpotomy and radiographs performed pre, intra, and postoperatively are included in the root canal reimbursement.

Root canal therapy that has only been initiated, or taken to some degree of completion, but not carried to completion with a final filling, may not be billed as a root canal therapy code. It must be billed using code D3999 with a narrative description of what procedures were completed in the root canal therapy.

Documentation supporting medical necessity must be kept in the client’s record and include the following: the medical necessity as documented through periapical radiographs of tooth treated showing pre-treatment, during treatment, and post-treatment status; the final size of the file to which the canal was enlarged; and the type of filling material used. Any reason that the root canal may appear radiographically unacceptable must be documented in the client’s record.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2957</td>
<td>Must be used with D2954. Not allowed on primary teeth. A 13-20, PXR, CCP</td>
<td>$37.50</td>
</tr>
<tr>
<td>D2960</td>
<td>A 13-20, N, PPXR, CCP</td>
<td>$112.50</td>
</tr>
<tr>
<td>D2961</td>
<td>A 13-20, N, PPXR, CCP</td>
<td>$181.25</td>
</tr>
<tr>
<td>D2962</td>
<td>A 13-20, N, PPXR, CCP</td>
<td>$212.50</td>
</tr>
<tr>
<td>D2970</td>
<td>May be reimbursed once per lifetime for each tooth, any provider.</td>
<td>$200.00</td>
</tr>
<tr>
<td>D2971*</td>
<td>May be reimbursed up to 4 services per lifetime for each tooth. Payable to any THSteps dental provider who performed the original cementation of the crown. A 13-20</td>
<td>$112.50</td>
</tr>
<tr>
<td>D2980</td>
<td>A 1-20, PXR (permanent teeth only)</td>
<td>$50.00</td>
</tr>
<tr>
<td>D2999</td>
<td>A 1-20, N, CCP, PXR</td>
<td>Manually priced</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
If the client is pregnant and does not want radiographs, use alternative treatment (temporary) until after delivery.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pulp Capping</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure codes D3110 and D3120 will not be reimbursed when billed with the following procedure codes for the same tooth, on the same day by the same provider: D2952, D2953, D2954, D2955, D2957, D2980, D2999, D3220, D3230, D3240, D3310, D3320, or D3330.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3110</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$16.25</td>
</tr>
<tr>
<td>D3120</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$30.00</td>
</tr>
</tbody>
</table>

| **Pulpotomy** |
| D3220* | Denied when performed within 6 months of D3230, D3240, D3310, D3320, or D3330 for the same primary TID, same provider. Denied when performed within 6 months of D3310, D3320 or D3330 on the same permanent TID, same provider. A Birth-20, PXR | $87.96 |
| D3221 | Denied as global fee to any endodontic procedure. | NC |

| **Endodontic Therapy on Primary Teeth** |
| D3230* | Anterior primary incisors and cuspids. TIDs #C-H; M-R. A 1-20, PXR | $38.75 |

| **Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)** |
| D3310* | A 6-20, PPXR | $355.98 |
| D3320* | A 6-20, PPXR | $412.50 |
| D3330* | A 6-20, PPXR | $624.26 |
| D3331 | Not payable, use retreatment codes. | NC |
| D3332 | Not payable, use retreatment codes. | NC |
| D3333 | Not payable, use retreatment codes. | NC |

| **Endodontic Retreatment** |
| D3346* | A 6-20, PPXR | $156.25 |
| D3347* | A 6-20, PPXR | $206.25 |
| D3348* | A 6-20, PPXR | $275.00 |

| **Apexification/Recalcification Procedures** |
| D3351* | A 6-20, N, PXR, CCP | $75.00 |
| D3352* | A 6-20, N, PXR, CCP | $50.00 |
| D3353* | A 6-20, PPXR, CCP | $100.00 |

| **Apicoectomy/Periradicular Services** |
| D3410 | A 6-20, N, PPXR, CCP | $131.25 |
| D3421 | A 6-20, N, PPXR, CCP | $162.50 |
| D3425 | A 6-20, N, PPXR, CCP | $162.50 |

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
5.3.16 Periodontal Services

Procedure codes D4210 and D4211, when billed for clients 12 years of age or younger, will be initially denied, but may be appealed with documentation of medical necessity. Preoperative and postoperative photographs are required for the following procedure codes: D4210, D4211, D4270, D4271, D4273, D4275, D4276, D4267, and D4266.

Preoperative and postoperative photographs are required when medical necessity is not evident on radiographs for the following procedure codes: D4240, D4241, D4245, D4266, and D4267. Documentation is required when medical necessity is not evident on radiographs for the following procedure codes: D4210, D4211, D4240, D4241, D4245, D4266, D4267, D4270, D4271, D4273, D4275, D4276, D4267, D4355, and D4910.

Claims for preventive dental procedure codes D1110, D1120, D1203, D1204, D1206, and D1351 will be denied with billed for the same DOS as any D4000 series periodontal procedure codes.

Procedure codes D4266 and D4267 may be appealed with documentation of medical necessity. Medical necessity for third molar sites are:

- Medical or dental history documenting need due to inadequate healing of bone following third molar extraction, including the date of third molar extraction.
- Secondary procedure several months postextraction.
- Position of the third molar preoperatively.
- Postextraction probing depth to document continuing bony defect.
- Postextraction radiographs documenting continuing bony defect.
- Bone graft and barrier material used.

Medical necessity for other than third molar sites are:

- Medical or dental history documenting comorbid condition (e.g., juvenile diabetes, cleft palate, avulsed tooth or teeth, traumatic oral injuries).

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3426</td>
<td>A 6-20, N, PPXR, CCP</td>
<td>$75.00</td>
</tr>
<tr>
<td>D3430</td>
<td>A 6-20, N, PPXR, CCP</td>
<td>$50.00</td>
</tr>
<tr>
<td>D3450</td>
<td>A 6-20, N, PXR, CCP</td>
<td>$75.00</td>
</tr>
<tr>
<td>D3460</td>
<td>Prior authorization required. Submit request with periapical radiographs, for each tooth involved. A 16-20, N, PPXR, CCP</td>
<td>$212.50</td>
</tr>
<tr>
<td>D3470</td>
<td>A 6-20, N, PXR, CCP</td>
<td>$125.00</td>
</tr>
</tbody>
</table>

Other Endodontic Procedures

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3910</td>
<td>A 1-20, N, CCP</td>
<td>$18.75</td>
</tr>
<tr>
<td>D3920</td>
<td>A 6-20, N, PXR, CCP</td>
<td>$81.25</td>
</tr>
<tr>
<td>D3950</td>
<td>A 6-20, N, PXR, CCP</td>
<td>$50.00</td>
</tr>
<tr>
<td>D3999</td>
<td>A 1-20, N, PXR, CCP</td>
<td>Manually priced</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, *= Services payable to an FQHC for a client encounter
- Intra- or extra-oral radiographs of treatment site(s).
- If not radiographically evident, intraoral photographs are optional unless requested preoperatively by HHSC or its agent.
- Periodontal probing depths.
- Number of intact walls associated with an angular bony defect.
- Bone graft and barrier material used.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>A 13-20, N, PPXR, PHO, CCP</td>
<td>$162.50</td>
</tr>
<tr>
<td>D4211</td>
<td>A 13-20, N, PHO, CCP</td>
<td>$50.00</td>
</tr>
<tr>
<td>D4230</td>
<td>A 13-20, N, PHO, PXR, CCP</td>
<td>$162.50</td>
</tr>
<tr>
<td>D4231</td>
<td>A 13-20, N, PHO, PXR, CCP</td>
<td>$97.50</td>
</tr>
<tr>
<td>D4240</td>
<td>A 13-20, N, FMX, PXR, PHO when medical necessity is not evident on radiographs, PC, CCP</td>
<td>$181.25</td>
</tr>
<tr>
<td>D4241</td>
<td>Limited to once per year. A 13-20, N, FMX, PXR, PHO when medical necessity is not evident on radiographs, PC</td>
<td>$55.00</td>
</tr>
<tr>
<td>D4245</td>
<td>Per quadrant. A 13-20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP</td>
<td>$181.25</td>
</tr>
<tr>
<td>D4249</td>
<td>A 6- to 8-week healing period following crown lengthening before final tooth preparation, impression making, and fabrication of a final restoration is required for billing of this code. A 13-20, N, PPXR, CCP</td>
<td>$162.50</td>
</tr>
<tr>
<td>D4260</td>
<td>A 13-20, N, FMX, PXR, PC, CCP</td>
<td>$225.00</td>
</tr>
<tr>
<td>D4261</td>
<td>Limited to once per year. A 13-20, N, FMX, PXR, PC</td>
<td>$67.00</td>
</tr>
<tr>
<td>D4265</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D4266</td>
<td>A 13-20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP</td>
<td>$275.00</td>
</tr>
<tr>
<td>D4267</td>
<td>A 13-20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP</td>
<td>$325.00</td>
</tr>
<tr>
<td>D4270</td>
<td>A 13-20, N, PXR, PHO, CCP</td>
<td>$193.75</td>
</tr>
<tr>
<td>D4271</td>
<td>A 13-20, N, PXR, PHO, CCP</td>
<td>$206.25</td>
</tr>
<tr>
<td>D4273</td>
<td>This procedure is performed to create or augment gingiva, to obtain root coverage or to eliminate frenum pull, or to extend the vestibular fornix. A 13-20, N, PXR, PHO, CCP</td>
<td>$225.00</td>
</tr>
<tr>
<td>D4274</td>
<td>This procedure is performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are used to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation. A 13-20, N, PXR, CCP</td>
<td>$125.00</td>
</tr>
<tr>
<td>D4275</td>
<td>Limited to once per day. A 13-20, PXR, PHO</td>
<td>$225.00</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4276</td>
<td>Prior authorization is required. Not payable in addition to D4273 or D4275 on the same DOS. A 13-20, PXR, PHO</td>
<td>$225.00</td>
</tr>
<tr>
<td>D4320</td>
<td>A 1-20, PXR</td>
<td>$62.50</td>
</tr>
<tr>
<td>D4321</td>
<td>A 1-20, PXR</td>
<td>$100.00</td>
</tr>
<tr>
<td>D4341*</td>
<td>D4341 is denied if provided within 21 days of D4355. Denied when billed on the same DOS as other D4000 series codes or with D1110, D1120, D1203, D1204. D1206, D1351, D1510, D1515, D1520 or D1525. A 13-20, FMX, PC, PXR, CCP</td>
<td>$56.25</td>
</tr>
<tr>
<td>D4342</td>
<td>Denied when billed on the same DOS as other D4000 series codes or with D1110, D1120, D1203, D1204. D1206, D1351, D1510, D1515, D1520 or D1525. A 13-20, PC, FMX</td>
<td>$7.00</td>
</tr>
<tr>
<td>D4355*</td>
<td>D4355 is not payable if provided within 21 days of D4341. Denied when billed on the same DOS as other D4000 series codes or with D1110, D1120, D1203, D1204. D1206, D1351, D1510, D1515, D1520 or D1525. A 13-20, N, PXR, PHO, CCP</td>
<td>$75.00</td>
</tr>
<tr>
<td>D4381</td>
<td>This procedure does not replace conventional or surgical therapy required for debridement, respective procedures, or regenerative therapy. The use of controlled-release chemotherapeutic agents is an adjunctive therapy or for cases in which systemic disease or other factors preclude conventional or surgical therapy. A 13-20, N, PXR, CCP</td>
<td>$30.00</td>
</tr>
<tr>
<td>D4910</td>
<td>Payable only following active periodontal therapy by any provider as evidenced either by a billed claim for procedure code D4240, D4241, D4260, or D4261 or by evidence through client records of periodontal therapy while not Medicaid-eligible. Not payable within 90 days after D4355, not payable on same DOS as any other evaluation procedure. Limited to once per 12 calendar months by the same provider. A 13-20, N, PXR, PHO, CCP</td>
<td>$37.50</td>
</tr>
<tr>
<td>D4920</td>
<td>A 13-20, N, PXR, CCP</td>
<td>$25.00</td>
</tr>
<tr>
<td>D4999</td>
<td>A 13-20, N, PXR, CCP</td>
<td>Manually priced</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *=Services payable to an FQHC for a client encounter.
### 5.3.17 Prosthodontic (Removable) Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complete Dentures (Including Routine Post Delivery Care)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5110</td>
<td>A 3-20, PXR</td>
<td>$375.00</td>
</tr>
<tr>
<td>D5120</td>
<td>A 3-20, PXR</td>
<td>$375.00</td>
</tr>
<tr>
<td>D5130</td>
<td>A 13-20, N, PXR, CCP</td>
<td>$387.50</td>
</tr>
<tr>
<td>D5140</td>
<td>A 13-20, N, PXR, CCP</td>
<td>$387.50</td>
</tr>
<tr>
<td><strong>Partial Dentures (Including Routine Post Delivery Care)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5211*</td>
<td>A 6-20, PXR, MTID</td>
<td>$275.00</td>
</tr>
<tr>
<td>D5212*</td>
<td>A 6-20, PXR, MTID</td>
<td>$275.00</td>
</tr>
<tr>
<td>D5213</td>
<td>A 9-20, N, PXR, MTID, CCP</td>
<td>$400.00</td>
</tr>
<tr>
<td>D5214</td>
<td>A 9-20, N, PXR, MTID, CCP</td>
<td>$400.00</td>
</tr>
<tr>
<td>D5281*</td>
<td>A 9-20, N, PXR, MTID, CCP</td>
<td>$250.00</td>
</tr>
<tr>
<td><strong>Adjustments to Dentures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5410</td>
<td>A 3-20, PXR</td>
<td>$18.75</td>
</tr>
<tr>
<td>D5411</td>
<td>A 3-20, PXR</td>
<td>$18.75</td>
</tr>
<tr>
<td>D5421</td>
<td>A 6-20, PXR</td>
<td>$18.75</td>
</tr>
<tr>
<td>D5422</td>
<td>A 6-20, PXR</td>
<td>$18.75</td>
</tr>
<tr>
<td><strong>Repairs to Complete Dentures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5510</td>
<td>Cost of repairs cannot exceed replacement costs. A 3-20, PXR</td>
<td>$50.00</td>
</tr>
<tr>
<td>D5520</td>
<td>Cost of repairs cannot exceed replacement costs. A 3-20, PXR</td>
<td>$43.75</td>
</tr>
<tr>
<td><strong>Repairs to Partial Dentures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of repairs cannot exceed replacement costs. A bill for the laboratory portion not to exceed $137.50 must be submitted.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5610*</td>
<td>A 3-20, PXR</td>
<td>$115.00</td>
</tr>
<tr>
<td>D5620</td>
<td>A 6-20, PXR</td>
<td>$56.25</td>
</tr>
<tr>
<td>D5630*</td>
<td>A 6-20, PXR</td>
<td>$50.00</td>
</tr>
<tr>
<td>D5640*</td>
<td>A 6-20, PXR</td>
<td>$43.75</td>
</tr>
<tr>
<td>D5650*</td>
<td>A 6-20, PXR</td>
<td>$50.00</td>
</tr>
<tr>
<td>D5660*</td>
<td>A 6-20, PXR</td>
<td>$62.50</td>
</tr>
<tr>
<td>D5670*</td>
<td>Will be denied as part of procedure codes D5211, D5213, D5281, and D5640. A 6-20</td>
<td>$175.00</td>
</tr>
<tr>
<td>D5671*</td>
<td>Will be denied as part of procedure codes D5212, D5214, D5281, and D5640. A 6-20</td>
<td>$175.00</td>
</tr>
<tr>
<td><strong>Denture Rebase Procedures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5710</td>
<td>A 4-20, PXR</td>
<td>$137.50</td>
</tr>
<tr>
<td>D5711</td>
<td>A 4-20, PXR</td>
<td>$137.50</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5720*</td>
<td>A 7-20, PXR</td>
<td>$137.50</td>
</tr>
<tr>
<td>D5721*</td>
<td>A 7-20, PXR</td>
<td>$137.50</td>
</tr>
</tbody>
</table>

**Denture Reline Procedures**

Allowed whether or not the denture was obtained through THSteps or ICF-MR dental services if the reline makes the denture serviceable.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5730</td>
<td>A 4-20, N, PXR, CCP</td>
<td>$81.25</td>
</tr>
<tr>
<td>D5731</td>
<td>A 4-20, N, PXR, CCP</td>
<td>$81.25</td>
</tr>
<tr>
<td>D5740*</td>
<td>A 7-20, N, PXR, CCP</td>
<td>$75.00</td>
</tr>
<tr>
<td>D5741*</td>
<td>A 7-20, N, PXR, CCP</td>
<td>$75.00</td>
</tr>
<tr>
<td>D5750</td>
<td>A 4-20, PXR</td>
<td>$118.75</td>
</tr>
<tr>
<td>D5751</td>
<td>A 4-20, PXR</td>
<td>$118.75</td>
</tr>
<tr>
<td>D5760*</td>
<td>A 7-20, PXR</td>
<td>$118.75</td>
</tr>
<tr>
<td>D5761*</td>
<td>A 7-20, PXR</td>
<td>$118.75</td>
</tr>
</tbody>
</table>

**Interim Prosthesis**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5810</td>
<td>A 3-20, N, PXR, CCP</td>
<td>$200.00</td>
</tr>
<tr>
<td>D5811</td>
<td>A 3-20, N, PXR, CCP</td>
<td>$200.00</td>
</tr>
<tr>
<td>D5820</td>
<td>A 3-20, N, PXR, CCP</td>
<td>$162.50</td>
</tr>
<tr>
<td>D5821</td>
<td>A 3-20, N, PXR, CCP</td>
<td>$162.50</td>
</tr>
</tbody>
</table>

**Other Removable Prosthetic Services**

<table>
<thead>
<tr>
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<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5850</td>
<td>A 3-20, N, PXR, CCP</td>
<td>$37.50</td>
</tr>
<tr>
<td>D5851</td>
<td>A 3-20, N, PXR, CCP</td>
<td>$37.50</td>
</tr>
<tr>
<td>D5860</td>
<td>A 4-20, N, PXR, CCP</td>
<td>$387.50</td>
</tr>
<tr>
<td>D5861</td>
<td>A 4-20, N, PXR, CCP</td>
<td>$387.50</td>
</tr>
<tr>
<td>D5862</td>
<td>A 4-20, N, PXR, CCP</td>
<td>$162.50</td>
</tr>
<tr>
<td>D5867</td>
<td>Denied as part of any repair or modification of any removable prosthetic.</td>
<td>NC</td>
</tr>
<tr>
<td>D5875</td>
<td>Denied as part of any repair or modification of any removable prosthetic.</td>
<td>NC</td>
</tr>
<tr>
<td>D5899</td>
<td>A 1-20, N, PXR, CCP</td>
<td>Manually priced</td>
</tr>
</tbody>
</table>

**Maxillofacial Prosthetics**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5911</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$50.00</td>
</tr>
<tr>
<td>D5912</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$90.00</td>
</tr>
<tr>
<td>D5913</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$875.00</td>
</tr>
<tr>
<td>D5914</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$875.00</td>
</tr>
<tr>
<td>D5915</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$875.00</td>
</tr>
<tr>
<td>D5916</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$562.50</td>
</tr>
</tbody>
</table>

A = Age range limitations, N = Narrative required, FMX = Full-mouth radiographs (nonpanoramic), MTID = Missing tooth ID[s], PPXR = Preoperative and postoperative radiographs required, PXR = Preoperative radiographs required, PHO = preoperative and postoperative photographs required, PC = Periodontal charting required, PATH = Pathology report required and must be retained in the client’s record, CCP = Comprehensive Care Program, NC = No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5919</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$1,125.00</td>
</tr>
<tr>
<td>D5922</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$140.00</td>
</tr>
<tr>
<td>D5923</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$337.50</td>
</tr>
<tr>
<td>D5924</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$437.50</td>
</tr>
<tr>
<td>D5925</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$375.00</td>
</tr>
<tr>
<td>D5926</td>
<td>A 1-20, N, PXR, CCP</td>
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<tr>
<td>D5927</td>
<td>A 1-20, N, PXR, CCP</td>
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</tr>
<tr>
<td>D5928</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$450.00</td>
</tr>
<tr>
<td>D5929</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$900.00</td>
</tr>
<tr>
<td>D5931</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$375.00</td>
</tr>
<tr>
<td>D5932</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$1,300.00</td>
</tr>
<tr>
<td>D5933</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$281.25</td>
</tr>
<tr>
<td>D5934</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$562.50</td>
</tr>
<tr>
<td>D5935</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$562.50</td>
</tr>
<tr>
<td>D5936</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$625.00</td>
</tr>
<tr>
<td>D5937</td>
<td>Not for temporo-mandibular dysfunction (TMD) treatment. A 1-20, N, PXR, CCP</td>
<td>$262.50</td>
</tr>
<tr>
<td>D5951</td>
<td>Prior authorization. A Birth-20, N, PXR</td>
<td>$140.00</td>
</tr>
<tr>
<td>D5952</td>
<td>Prior authorization. A Birth-20, N, PXR</td>
<td>$843.75</td>
</tr>
<tr>
<td>D5953</td>
<td>Prior authorization. A 13-20, N, PXR</td>
<td>$843.75</td>
</tr>
<tr>
<td>D5954</td>
<td>Prior authorization. A Birth-20, N, PXR</td>
<td>$443.75</td>
</tr>
<tr>
<td>D5955</td>
<td>Prior authorization. A Birth-20, N, PXR</td>
<td>$225.00</td>
</tr>
<tr>
<td>D5958</td>
<td>Prior authorization. A Birth-20, N, PXR</td>
<td>$225.00</td>
</tr>
<tr>
<td>D5959</td>
<td>Prior authorization. A Birth-20, N, PXR</td>
<td>$100.00</td>
</tr>
<tr>
<td>D5960</td>
<td>Prior authorization. A Birth-20, N, PXR</td>
<td>$100.00</td>
</tr>
<tr>
<td>D5982</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$112.50</td>
</tr>
<tr>
<td>D5983</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$162.50</td>
</tr>
<tr>
<td>D5984</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$162.50</td>
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<tr>
<td>D5985</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$162.50</td>
</tr>
<tr>
<td>D5986</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$50.00</td>
</tr>
<tr>
<td>D5987</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$131.25</td>
</tr>
<tr>
<td>D5988</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$112.50</td>
</tr>
<tr>
<td>D5999</td>
<td>A 1-20, N, PXR, CCP</td>
<td>Manually priced</td>
</tr>
</tbody>
</table>

A = Age range limitations, N = Narrative required, FMX = Full-mouth radiographs (nonpanoramic), MTID = Missing tooth ID(s), PPXR = Preoperative and postoperative radiographs required, PXR = Preoperative radiographs required, PHO = Preoperative and postoperative photographs required, PC = Periodontal charting required, PATH = Pathology report required and must be retained in the client's record, CCP = Comprehensive Care Program, NC = No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
5.3.18 Implant Services

All of the following implant services codes require prior authorization. Procedure codes D6092 and D6093 do not require prior authorization.

Refer to: Subsection 5.3.29, “Mandatory Prior Authorization” in this handbook for documentation requirements.

Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by the TMHP Dental Director are:

- At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).
- Space cannot be filled with removable partial denture.
- The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6010</td>
<td>Includes second stage surgery and placement of healing cap. A 16-20, N, PPXR, CCP</td>
<td>$1,125.00</td>
</tr>
<tr>
<td>D6040</td>
<td>A 16-20, N, PPXR, CCP</td>
<td>$2,000.00</td>
</tr>
<tr>
<td>D6050</td>
<td>A 16-20, N, PPXR, CCP</td>
<td>Manually priced</td>
</tr>
</tbody>
</table>

**Implant Supported Prosthetics**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6053</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6054</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6055</td>
<td>A 16-20, N, PXR, CCP</td>
<td>$300.00</td>
</tr>
<tr>
<td>D6056</td>
<td>Includes placement. May include the removal of a temporary healing cap or replacement with an abutment of alternate design. Mandatory prior authorization. A 16-20, N, PPXR, CCP</td>
<td>$350.00</td>
</tr>
<tr>
<td>D6057</td>
<td>Includes placement. May include the removal of a temporary healing cap or replacement with an abutment of alternate design. Mandatory prior authorization. A 16-20, N, PPXR, CCP</td>
<td>$350.00</td>
</tr>
<tr>
<td>D6058</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6059</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6060</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6061</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6062</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6063</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6064</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6065</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6066</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6067</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6068</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PPX=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *=Services payable to an FQHC for a client encounter.
5.3.19 Prosthodontic (Fixed) Services

Prosthodontic procedure codes require prior authorization.

Refer to: Subsection 5.3.29, “Mandatory Prior Authorization” in this handbook for documentation requirements.

Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by the TMHP Dental Director are:

- At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).
- The space cannot be filled with a removable partial denture.
- The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).
- Each abutment or each pontic constitutes a unit in a bridge.
- Porcelain is allowed on all teeth.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6069</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6070</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6071</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6072</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6073</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6074</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6075</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6076</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6077</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6078</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6079</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D6080</td>
<td>A 16-20, N, PXR, CCP</td>
<td>$43.75</td>
</tr>
<tr>
<td>D6090</td>
<td>A 16-20, N, PXR, CCP</td>
<td>$137.50</td>
</tr>
<tr>
<td>D6092</td>
<td>Limited to once per year for each tooth by any provider. A 16-20</td>
<td>$46.85</td>
</tr>
<tr>
<td>D6093</td>
<td>Limited to once per year for each tooth by any provider. A 16-20</td>
<td>$46.85</td>
</tr>
<tr>
<td>D6095</td>
<td>Involves the surgical removal of an implant. A 16-20, N, PPXR, CCP</td>
<td>$175.00</td>
</tr>
<tr>
<td>D6100</td>
<td>A 16-20, N, PXR, CCP</td>
<td>$225.00</td>
</tr>
<tr>
<td>D6199</td>
<td>A 16-20, N, PXR, CCP</td>
<td>Manually priced</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and * = Services payable to an FQHC for a client encounter.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Max Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6210</td>
<td>A 16-20, PPXR, MTID, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D6211</td>
<td>A 16-20, PPXR, MTID, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D6212</td>
<td>A 16-20, PPXR, MTID, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D6240</td>
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<td>D6241</td>
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<tr>
<td>D6242</td>
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<tr>
<td>D6245</td>
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<td>D6250</td>
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</tr>
<tr>
<td>D6251</td>
<td>A 16-20, PPXR, MTID, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D6252</td>
<td>A 16-20, PPXR, MTID, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D6253</td>
<td>Denied as global to other services.</td>
<td>NC</td>
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</table>

### Fixed Partial Dental Retainers—Inlays/Onlays

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Max Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6545</td>
<td>A 16-20, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D6548</td>
<td>A 16-20, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D6600</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6601</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6602</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6603</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6604</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6605</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6606</td>
<td>Denied as global to other services.</td>
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</tr>
<tr>
<td>D6607</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6608</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6609</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6610</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6611</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6612</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6613</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6614</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D6615</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
</tbody>
</table>

### Fixed Partial Dental Retainers—Crowns

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Max Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6720</td>
<td>A 16-20, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D6721</td>
<td>A 16-20, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D6722</td>
<td>A 16-20, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D6740</td>
<td>A 16-20, PPXR, CCP</td>
<td>$264.00</td>
</tr>
</tbody>
</table>

**Notes:**
- A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
5.3.20 Oral and Maxillofacial Surgery Services

All oral surgery procedures include local anesthesia, suturing, if needed, and visits for routine postoperative care.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Max Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6750</td>
<td>A 16-20, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D6751</td>
<td>A 16-20, PPXR, CCP</td>
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<tr>
<td>D6752</td>
<td>A 16-20, PPXR, CCP</td>
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</tr>
<tr>
<td>D6780</td>
<td>A 16-20, PPXR, CCP</td>
<td>$264.00</td>
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<tr>
<td>D6781</td>
<td>A 16-20, PPXR, CCP</td>
<td>$264.00</td>
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<td>D6782</td>
<td>A 16-20, PPXR, CCP</td>
<td>$264.00</td>
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<tr>
<td>D6783</td>
<td>A 16-20, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D6790</td>
<td>Permanent posterior teeth only. A 16-20, PPXR, CCP</td>
<td>$264.00</td>
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<tr>
<td>D6791</td>
<td>Permanent posterior teeth only. A 16-20, PPXR, CCP</td>
<td>$264.00</td>
</tr>
<tr>
<td>D6792</td>
<td>Permanent posterior teeth only. A 16-20, PPXR, CCP</td>
<td>$264.00</td>
</tr>
</tbody>
</table>

Other Fixed Partial Dental

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation(s)</th>
<th>Max Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6920</td>
<td>A 16-20, PXR, CCP</td>
<td>$135.00</td>
</tr>
<tr>
<td>D6930</td>
<td>A 16-20, PXR, CCP</td>
<td>$37.50</td>
</tr>
<tr>
<td>D6940</td>
<td>A 16-20, N, PXR, CCP</td>
<td>$87.50</td>
</tr>
<tr>
<td>D6950</td>
<td>A 16-20, N, PXR, CCP</td>
<td>$137.50</td>
</tr>
<tr>
<td>D6970</td>
<td>A 16-20, N, PXR, CCP</td>
<td>$100.00</td>
</tr>
<tr>
<td>D6972</td>
<td>A 16-20, N, PXR, CCP</td>
<td>$81.25</td>
</tr>
<tr>
<td>D6973</td>
<td>A 16-20, N, PXR, CCP</td>
<td>$56.25</td>
</tr>
<tr>
<td>D6975</td>
<td>A 16-20, N, PXR, CCP</td>
<td>$125.00</td>
</tr>
<tr>
<td>D6976</td>
<td>Must be used with D6970. Prior authorization required. A 16-20, PXR, CCP</td>
<td>$50.00</td>
</tr>
<tr>
<td>D6977</td>
<td>Must be used with D6972. Prior authorization required. A 16-20, PXR, CCP</td>
<td>$40.63</td>
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<tr>
<td>D6980</td>
<td>A 16-20, N, PXR, CCP</td>
<td>$68.75</td>
</tr>
<tr>
<td>D6999</td>
<td>A 16-20, N, PXR, CCP</td>
<td>Manually priced</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7140*</td>
<td>Replaces procedure codes D7110, D7120, and D7130. A Birth-20, PXR</td>
<td>$67.04</td>
</tr>
<tr>
<td></td>
<td><strong>Surgical Extractions</strong></td>
<td></td>
</tr>
<tr>
<td>D7210*</td>
<td>Includes removal of the roots of a previously erupted tooth missing its clinical crown. A 1-20, PXR</td>
<td>$102.81</td>
</tr>
<tr>
<td>D7220*</td>
<td>A 1-20, PXR</td>
<td>$157.50</td>
</tr>
<tr>
<td>D7230*</td>
<td>A 1-20, PXR</td>
<td>$180.00</td>
</tr>
<tr>
<td>D7240</td>
<td>A 1-20, PXR</td>
<td>$300.00</td>
</tr>
<tr>
<td>D7241</td>
<td>Document unusual circumstance. A 1-20, N, PXR</td>
<td>$156.25</td>
</tr>
<tr>
<td>D7250*</td>
<td>Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft and/or hard tissue healing has occurred. A 1-20, N, PXR</td>
<td>$92.50</td>
</tr>
<tr>
<td></td>
<td><strong>Other Surgical Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>D7260</td>
<td>A 1-20, N, PXR; TIDs #1-16 only.</td>
<td>$137.50</td>
</tr>
<tr>
<td>D7261</td>
<td>May not be paid on the same day as D7260; TIDs #1-16 only. A 1-20</td>
<td>$137.50</td>
</tr>
<tr>
<td>D7270*</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$110.00</td>
</tr>
<tr>
<td>D7272</td>
<td>Requires prior authorization. A 1-20, N, PXR, CCP</td>
<td>$150.00</td>
</tr>
<tr>
<td>D7280</td>
<td>A 1-20, N, PXR</td>
<td>$62.50</td>
</tr>
<tr>
<td>D7282</td>
<td>Permanent TIDs #1-32 only; may not be paid on the same day as D7280. A 4-20</td>
<td>$62.50</td>
</tr>
<tr>
<td>D7283</td>
<td>A 1-20</td>
<td>$25.00</td>
</tr>
<tr>
<td>D7285</td>
<td>A 1-20, PXR, PATH, CCP</td>
<td>$75.00</td>
</tr>
<tr>
<td>D7286*</td>
<td>A 1-20, PXR, PATH</td>
<td>$62.50</td>
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<tr>
<td>D7287</td>
<td>Denied as global to other services.</td>
<td>NC</td>
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<tr>
<td>D7290</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$137.50</td>
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<tr>
<td>D7291</td>
<td>A 4-20, N, PXR, CCP</td>
<td>$50.00</td>
</tr>
<tr>
<td></td>
<td><strong>Alveoloplasty—Surgical Preparation of Ridge for Dentures</strong></td>
<td></td>
</tr>
<tr>
<td>D7310</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$56.25</td>
</tr>
<tr>
<td>D7320</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$75.00</td>
</tr>
<tr>
<td></td>
<td><strong>Vestibuloplasty</strong></td>
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</tr>
<tr>
<td>D7340</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$125.00</td>
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<tr>
<td>D7350</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$250.00</td>
</tr>
<tr>
<td></td>
<td><strong>Surgical Excision of Soft Tissue Lesions</strong></td>
<td></td>
</tr>
<tr>
<td>D7410</td>
<td>A 1-20, PXR, PATH</td>
<td>$100.00</td>
</tr>
<tr>
<td>D7411</td>
<td>A 1-20, PXR, PATH</td>
<td>$150.00</td>
</tr>
<tr>
<td>D7412</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
### Children's Services Handbook

#### Procedure Code and Maximum Fee

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7413</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP</td>
<td>$100.00</td>
</tr>
<tr>
<td>D7414</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP</td>
<td>$150.00</td>
</tr>
<tr>
<td>D7415</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D7440</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP</td>
<td>$181.25</td>
</tr>
<tr>
<td>D7441</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP</td>
<td>$237.50</td>
</tr>
<tr>
<td>D7450</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP</td>
<td>$118.75</td>
</tr>
<tr>
<td>D7451</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP</td>
<td>$162.50</td>
</tr>
<tr>
<td>D7460</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth-20, N, PXR, PATH, CCP</td>
<td>$118.75</td>
</tr>
<tr>
<td>D7461</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth-20, N, PXR, PATH, CCP</td>
<td>$162.50</td>
</tr>
<tr>
<td>D7465</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP</td>
<td>$68.75</td>
</tr>
<tr>
<td>D7471</td>
<td>Denied as global to all extractions.</td>
<td>NC</td>
</tr>
<tr>
<td>D7472</td>
<td>Prior authorization is required. A 1-20</td>
<td>$160.00</td>
</tr>
<tr>
<td>D7473</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D7485</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D7490</td>
<td>Denied as global to other services.</td>
<td>NC</td>
</tr>
<tr>
<td>D7510*</td>
<td>TID required. A 1-20, PXR</td>
<td>$37.50</td>
</tr>
<tr>
<td>D7520</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$125.00</td>
</tr>
<tr>
<td>D7530</td>
<td>A 1-20, N, PXR</td>
<td>$50.00</td>
</tr>
<tr>
<td>D7540</td>
<td>A 1-20, N, PXR</td>
<td>$100.00</td>
</tr>
<tr>
<td>D7550*</td>
<td>A 1-20, N, PXR</td>
<td>$106.25</td>
</tr>
</tbody>
</table>

**A** = Age range limitations, **N** = Narrative required, **FMX** = Full-mouth radiographs (nonpanoramic), **MTID** = Missing tooth ID(s), **PPXR** = Preoperative and postoperative radiographs required, **PXR** = Preoperative radiographs required, **PHO** = Preoperative and postoperative photographs required, **PC** = Periodontal charting required, **PATH** = Pathology report required and must be retained in the client’s record, **CCP** = Comprehensive Care Program, **NC** = No charge to Medicaid and may not bill the client, and **=** Services payable to an FQHC for a client encounter.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7560</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$125.00</td>
</tr>
<tr>
<td>D7670</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$81.25</td>
</tr>
<tr>
<td>D7671</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D7771</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
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</table>

**Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7820</td>
<td>A 1-20, N, PXR</td>
<td>$81.25</td>
</tr>
<tr>
<td>D7830</td>
<td>Refer to CPT codes.</td>
<td>NC</td>
</tr>
<tr>
<td>D7880</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$140.00</td>
</tr>
<tr>
<td>D7899</td>
<td>A 1-20, N, PXR, CCP</td>
<td>Manually priced</td>
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</tbody>
</table>

**Repair of Traumatic Wounds**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7910*</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$75.00</td>
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</tbody>
</table>

**Complicated Suturing**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7911</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$81.25</td>
</tr>
<tr>
<td>D7912</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$162.50</td>
</tr>
</tbody>
</table>

**Other Repair Procedures**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7960</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$105.00</td>
</tr>
<tr>
<td>D7970*</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$112.50</td>
</tr>
<tr>
<td>D7971*</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$43.75</td>
</tr>
<tr>
<td>D7972</td>
<td>TIDs #1, 16, 17, and 32 only; may not be paid in addition to D7971 on the same day. A 13-20</td>
<td>$43.75</td>
</tr>
<tr>
<td>D7980</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$193.75</td>
</tr>
<tr>
<td>D7983</td>
<td>A 1-20, N, PXR, CCP</td>
<td>$162.50</td>
</tr>
<tr>
<td>D7997*</td>
<td>Per arch, appliance removal (not by the dentist who placed the appliance). Includes removal of arch bar. Prior authorization is required. A 1-20, N, PXR, CCP</td>
<td>$50.00</td>
</tr>
<tr>
<td>D7999*</td>
<td>A 1-20, N, PXR, CCP</td>
<td>Manually priced</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
### 5.3.21 Adjunctive General Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unclassified Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9110*</td>
<td>Emergency service only. The type of treatment rendered and TID must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked. Refer to Subsection 5.3.27, “Emergency and/or Trauma Related Services for All THSteps Clients and Clients 5 Months of Age or Younger” in this handbook</td>
<td>$18.75</td>
</tr>
<tr>
<td>D9120</td>
<td></td>
<td>$20.00</td>
</tr>
<tr>
<td><strong>Anesthesia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Refer to:</strong> Subsection 5.3.22.1, “Criteria for Dental Therapy Under General Anesthesia” in this handbook for general anesthesia criteria and additional information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9210</td>
<td>Claim form narrative should describe the situation if used as a diagnostic tool. Denied if billed with D9248. A 1-20, N, CCP</td>
<td>$12.50</td>
</tr>
<tr>
<td>D9211*</td>
<td>Denied if billed with D9248. A 1-20, N, CCP</td>
<td>$18.75</td>
</tr>
<tr>
<td>D9212*</td>
<td>Denied if billed with D9248. A 1-20, N, CCP</td>
<td>$31.25</td>
</tr>
<tr>
<td>D9215*</td>
<td>Claim form narrative should explain how the doctor initiated a procedure, but could not complete it, and needs to claim the rendered anesthesia. Denied if billed with D9248. A 1-20, N, CCP</td>
<td>$12.50</td>
</tr>
<tr>
<td>D9220</td>
<td>May be billed with D9221. May be billed twice within a 12-month period. Denied if billed with D9248. Dental anesthesiologists are reimbursed at a rate of $202.55. A 1-20</td>
<td>$87.50</td>
</tr>
<tr>
<td>D9221</td>
<td>Must be billed with D9220. Denied if billed with D9248. A 1-20</td>
<td>$31.25</td>
</tr>
<tr>
<td>D9230*</td>
<td>May not be billed more than one per client, per day. Denied if billed with D9248. A 1-20.</td>
<td>$28.38</td>
</tr>
<tr>
<td>D9241</td>
<td>May be considered for reimbursement for conscious sedation services. Denied if billed with D9248. A 1-20</td>
<td>$121.88</td>
</tr>
<tr>
<td>D9242</td>
<td>Must be billed with D9241. May be considered for reimbursement for additional conscious sedation services. Denied if billed with D9248. A 1-20</td>
<td>$29.02</td>
</tr>
<tr>
<td>D9248*</td>
<td>May be billed twice within a 12-month period. Must comply with all TSBDE rules and AAPD guidelines, including maintaining a current permit to provide non-intravenous (IV) conscious sedation. A 1-20</td>
<td>$187.50</td>
</tr>
<tr>
<td><strong>Professional Consultation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9310</td>
<td>An oral evaluation by a specialist of any type who is also providing restorative or surgical services should be billed as D0160. A 1-20, N, CCP</td>
<td>$15.25</td>
</tr>
<tr>
<td><strong>Professional Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9410</td>
<td>Narrative required on claim form. A 1-20, N</td>
<td>$25.00</td>
</tr>
</tbody>
</table>

---

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
### Procedure Code | Limitations | Maximum Fee
--- | --- | ---
D9420 | One charge per hospital or ASC case; one case per client in a 12-month period. Documentation supporting the reason that dental services could not be performed in the office setting must be retained in the client’s record and may be subject to retrospective review and recoupment. A 1-20, N | $38.00
D9430 | During regularly scheduled hours, no other services performed. Visits for routine postoperative care are included in all therapeutic and oral surgery fees. A 1-20, N | $15.00
D9440 | Visits for routine postoperative care are included in all therapeutic and oral surgery fees. A 1-20, N | $31.25
D9450 | Denied as global to other services. | NC

### Drugs
Procedure code D9630 is not payable for take home fluorides or drugs. Prescriptions should be given to clients to be filled by the pharmacy for these medications as the pharmacy is reimbursed by the Medicaid Vendor Drug Program. Procedure code D9630 is payable for medications (antibiotics, analgesics, etc.) administered to a client in the provider’s office. Documentation of dosage and route of administration must be provided in the Remarks section of the claim.


<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9610</td>
<td>May not be billed with code D9220 or D9221. A 1-20, N</td>
<td>$18.75</td>
</tr>
<tr>
<td>D9612</td>
<td></td>
<td>$37.50</td>
</tr>
<tr>
<td>D9630</td>
<td>Includes, but is not limited to, oral antibiotics, oral analgesic, and oral sedatives administered in the office. May not be billed with codes D9220, D9221, D9230, D9241, D9248, D9610, and D9920. A 1-20, N</td>
<td>$9.00</td>
</tr>
</tbody>
</table>

### Miscellaneous Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9910</td>
<td>Per whole mouth application, does not include fluoride. Not to be used for bases, liners, or adhesives under or with restorations. Limited to once per year. A 18-20, N, CCP</td>
<td>$12.50</td>
</tr>
<tr>
<td>D9911</td>
<td>Denied as part of D9910.</td>
<td>NC</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
The provider must indicate the client’s medical diagnosis of mental retardation using one of the following diagnosis codes or indicate that the client is ICF-MR eligible in the Remarks field of the claim form:

- 317 - mild mental retardation (IQ 50-70)
- 3180 - moderate mental retardation (IQ 35-49)
- 3181 - severe mental retardation (IQ 20-34)
- 3182 - profound mental retardation (IQ under 20)
- 319 - unspecified mental retardation

Documentation supporting the medical necessity and appropriateness of dental behavior management must be retained in the client’s chart and available to state agencies upon request, and is subject to retrospective review. Documentation of medical necessity must include:

- A current physician statement addressing the mental retardation. The statement must be signed and dated within one year prior to the dental behavior management.
- A description of the service performed (including the specific problem and the behavior management technique applied).
- Personnel and supplies required to provide the behavioral management.
- The duration of the behavior management (including session start and end times).

Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure. Denied if billed with D9248. A 1-20

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9920</td>
<td>The provider must indicate the client’s medical diagnosis of mental retardation using one of the following diagnosis codes or indicate that the client is ICF-MR eligible in the Remarks field of the claim form: 317 - mild mental retardation (IQ 50-70), 3180 - moderate mental retardation (IQ 35-49), 3181 - severe mental retardation (IQ 20-34), 3182 - profound mental retardation (IQ under 20), 319 - unspecified mental retardation. Documentation supporting the medical necessity and appropriateness of dental behavior management must be retained in the client’s chart and available to state agencies upon request, and is subject to retrospective review. Documentation of medical necessity must include: A current physician statement addressing the mental retardation. The statement must be signed and dated within one year prior to the dental behavior management. A description of the service performed (including the specific problem and the behavior management technique applied). Personnel and supplies required to provide the behavioral management. The duration of the behavior management (including session start and end times). Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure. Denied if billed with D9248. A 1-20</td>
<td>$50.00</td>
</tr>
<tr>
<td>D9930*</td>
<td>A 1-20, N</td>
<td>$25.00</td>
</tr>
<tr>
<td>D9940</td>
<td>A 13-20, N, CCP</td>
<td>$118.75</td>
</tr>
<tr>
<td>D9950</td>
<td>A 13-20, N, CCP</td>
<td>$56.25</td>
</tr>
<tr>
<td>D9951</td>
<td>Full mouth procedure. Limited to once per year, per client, any provider. A 13-20, N, CCP</td>
<td>$37.50</td>
</tr>
<tr>
<td>D9952</td>
<td>Full mouth procedure. Payable once per lifetime, any provider. A 13-20, N, CCP</td>
<td>$150.00</td>
</tr>
<tr>
<td>D9970</td>
<td>One service per day, any provider. A 13-20</td>
<td>$56.25</td>
</tr>
<tr>
<td>D9971</td>
<td>Not payable; bill as extractions.</td>
<td>NC</td>
</tr>
<tr>
<td>D9972</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D9973</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D9974*</td>
<td>Claim must include documentation of medical necessity. A 13-20, CCP</td>
<td>$56.25</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PPHO=preoperative and postoperative photographs required, PE=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and * Services payable to an FQHC for a client encounter.
5.3.22 Dental Therapy Under General Anesthesia

Providers must comply with TSBDE Rules and Regulations, Chapter 8, Subsection C and 22 TAC §108.30 - 108.35. Any anesthesia type services are paid only to the provider. The dental provider is responsible for determining whether a client meets the minimum criteria necessary for receiving general anesthesia. A local anesthesia fee is not paid in addition to other restorative, operative, or surgical procedure fees.

General anesthesia (provided in the dentist office, ambulatory surgical center, and inpatient/outpatient hospital settings) requires prior authorization. All THSteps dental charts for dental general anesthesia are subject to retrospective, random review for compliance with the Criteria for Dental Therapy Under General Anesthesia and requirements for chart documentation. Dental general anesthesia may be reimbursed once every six months per client per provider.

Dental rehabilitation or restoration services requiring general anesthesia are performed in an outpatient facility.

Surgical services related to THSteps dental services requiring general anesthesia must be coded as follows:

- Procedure code 00170 with modifier EP is for the anesthesiologist or certified registered nurse anesthetist (CRNA) to use on the claim form.
- Procedure code 41899 with modifier EP is for the facility to use on the claim form. Procedure code 41899 does not require prior authorization for ASCs and HASCs.
- An appropriate diagnosis codes, such as 52100 and 5220, must be used on the claim form.
- Modifier EP identifies that the service is associated with THSteps.

The claim forms used are the CMS-1500 or the UB-04 CMS-1450. The examining physician, anesthesiologist, hospital, ASC, or HASC must bill TMHP or the appropriate MCO separately for the medical and facility components of their services.

Refer to: Form CH.14, "THSteps Dental Mandatory Prior Authorization Request Form" in this handbook.

Subsection 5.3.22.1, “Criteria for Dental Therapy Under General Anesthesia” in this handbook.

Subsection 5.3.22.2, “Criteria for Dental Therapy Under General Anesthesia, Attachment 1” in this handbook.
Criteria for Dental Therapy Under General Anesthesia

Total points needed to justify treatment under general anesthesia = 22.

<table>
<thead>
<tr>
<th>Age of client at time of examination</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than four years of age</td>
<td>8</td>
</tr>
<tr>
<td>Four and five years of age</td>
<td>6</td>
</tr>
<tr>
<td>Six and seven years of age</td>
<td>4</td>
</tr>
<tr>
<td>Eight years of age and older</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Requirements (Caries and/or Abscessed Teeth)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 teeth or one sextant</td>
<td>3</td>
</tr>
<tr>
<td>3-4 teeth or 2-3 sextants</td>
<td>6</td>
</tr>
<tr>
<td>5-8 teeth or 4 sextants</td>
<td>9</td>
</tr>
<tr>
<td>9 or more teeth or 5-6 sextants</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavior of Client**</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely negative—unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability</td>
<td>10</td>
</tr>
<tr>
<td>Somewhat negative—defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator’s hand, refusal to take radiographs</td>
<td>4</td>
</tr>
<tr>
<td>Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal responses and are not indications for treatment under general anesthesia</td>
<td>0</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

<table>
<thead>
<tr>
<th>Additional Factors**</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention**</td>
<td>15</td>
</tr>
<tr>
<td>Failed conscious sedation**</td>
<td>15</td>
</tr>
<tr>
<td>Medically compromising of handicapping condition**</td>
<td>15</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

I understand and agree with the dentist’s assessment of my child's behavior.

PARENT/GUARDIAN SIGNATURE: ___________________________________________ DATE: ________________

Clients in need of general anesthesia who do not meet the 22-point threshold, by report, will require prior authorization.

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the client’s chart. The client’s chart must be available for review by representatives of TMHP and/or HHSC.

PERFORMING DENTIST’S SIGNATURE: ___________________________________________ DATE: ________________ License No. ____________________________

Effective Date, 01012009/Revised Date, 12172008
Medicaid Dental Policy Regarding Criteria for Dental Therapy Under General Anesthesia–Attachment 1

Purpose: To justify I.V. Sedation or General Anesthesia for Dental Therapy, the following documentation is required in the Child’s Dental Record.

Elements: Note those required* and those as appropriate**:

1) The medical evaluation justifying the need for anesthesia
2) Description of relevant behavior and reference scale
3) Other relevant narrative justifying the need for general anesthesia.
4) Client’s demographics, including date of birth.
5) Relevant dental and medical history.
6) Dental radiographs, intraoral/suboral photography and/or diagram of dental pathology.
7) Proposed Dental Plan of Care.
8) Consent signed by parent/guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained.
10) The parent/guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist’s assessment of their child’s behavior.
11) Dentist’s attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand alone form.

*I attest that the client’s condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the client’s record and is available in my office.*

REQUESTING DENTIST’S SIGNATURE: ____________________________ DATE: ________________
5.3.23 Hospitalization and ASC/HASC

Dental services performed in an ASC, HASC, or a hospital (either as an inpatient or an outpatient) may be benefits of THSteps based on the medical or behavioral justification provided, or if one of the following conditions exist:

- The procedures cannot be performed in the dental office.
- The client is severely disabled.

To satisfy the preadmission history and physical examination requirements of the hospital, ASC, or HASC, a THSteps medical checkup for dental rehabilitation or restoration may be performed by the child’s primary care provider. Physicians who are not enrolled as THSteps medical providers should bill for the examination of a client before the procedure with the appropriate evaluation and management procedure code from the following table:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Place of Service (POS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>POS 1 (office)</td>
</tr>
<tr>
<td>99222</td>
<td>POS 3 (inpatient hospital)</td>
</tr>
<tr>
<td>99282</td>
<td>POS 5 (outpatient hospital)</td>
</tr>
</tbody>
</table>

Providers enrolled in THSteps Medical should refer to subsection 6.3.1.6, “Exception-to-Periodicity Checkups” in this handbook.

Note: The dental provider should bill TMHP using the ADA Dental Claim Form to be considered for reimbursement through THSteps Dental Services.

Contact the individual HMO for precertification requirements related to the hospital procedure. If services are precertified, the provider receives a precertification number effective for 90 days.

In those areas of the state with Medicaid managed care, the provider should contact the managed care plan for specific requirements or limitations. It is the dental provider’s responsibility to obtain precertification from the client’s HMO or managed care plan for facility and general anesthesia services if precertification is required.

To be reimbursed by the HMO, the provider must use the HMO’s contracted facility and anesthesia provider. These services are included in the capitation rates paid to HMOs, and the facility or anesthesiologist risk nonpayment from the HMO without such approval. Coordination of all specialty care is the responsibility of the client’s primary care provider. The primary care provider must be notified by the dentist or the HMO of the planned services.

Dentists providing sedation or anesthesia services must have the appropriate current permit from the TSBDE for the level of sedation or anesthesia provided.

The dental provider must be in compliance with the guidelines detailed in General Information.

Note: Post-treatment authorization will not be approved for codes that require mandatory prior authorization.

5.3.24 Orthodontic Services (THSteps)

Orthodontic services for cosmetic purposes only are not a benefit of Texas Medicaid. Orthodontic services are limited to the treatment of children 12 years of age or older with severe handicapping malocclusion, children birth through 20 years of age with cleft palate, or other special medically necessary circumstances as outlined in Benefits and Limitations, which follows.
5.3.24.1 Benefits and Limitations

Orthodontic services include the following:

- Correction of severe handicapping malocclusion as measured on the Handicapping Labiolingual Deviation (HLD) Index. Refer to subsection 5.3.26, “How to Score the Handicapping Labio-lingual Deviation (HLD) Index” in this handbook for information on how to score the HLD. A minimum score of 26 points is required for full banding approval (only permanent dentition cases are considered).

  **Exception:** Retained deciduous teeth and cleft palates with gross malocclusion that will benefit from early treatment. Cleft palate cases do not have to meet the HLD 26-point scoring requirement. However, it is necessary to submit a sufficient narrative and/or outline of the proposed treatment plan when requesting authorization for orthodontic services on cleft palate cases.

- Crossbite therapy.

- Head injury involving severe traumatic deviation.

The following limitations apply for orthodontic services:

- Orthodontic services for cosmetic purposes only are not a benefit of Texas Medicaid or THSteps.

- Orthognathic surgery, to include extractions, required or provided in conjunction with the application of braces must be completed while the client is Medicaid-eligible in order for reimbursement to be considered.

- Except for procedure code D8660, all orthodontic procedures require prior authorization for consideration of reimbursement.

- The THSteps client must be Medicaid THSteps-eligible when authorization is requested and the orthodontic treatment plan is initiated. It is the provider’s responsibility to verify that the client has a current Medicaid Identification Form (Form H3087) or Medicaid Eligibility Verification Form (Forms H1027 and H1027-A-C); that the date of birth on the form indicates the client is 20 years of age or younger; and that no limitations are indicated.

- Prior authorization is issued to the requesting provider only and is not transferable to another provider. If the client changes providers or if the provider ceases to be a Medicaid provider for any reason, a new prior authorization must be requested by the new provider.

  **Refer to:** Subsection 5.3.24.4, “Transfer of Orthodontic Services” in this handbook.

The following procedure codes, policies, and limitations are applied to the processing and payment of orthodontic services under THSteps dental services:

- Procedure code D8660 is allowed when:
  - The client is referred to a dental provider to determine whether orthodontic services are indicated and to determine the appropriate time to initiate such services.
  - The client is referred to a dental provider and elects to receive services from another orthodontic provider for justifiable reasons.
  - Repeat visits at different age levels are required to determine the appropriate time to initiate orthodontic treatment.
  - If procedure code D8660 is billed within six months of procedure code D8080, procedure code D8080 will be reduced by the amount that was paid for procedure code D8660.
  - Procedure code D8680 is payable for one retainer per arch, per lifetime, and each retainer may be replaced once because of loss or breakage (prior authorization is required).
• Procedure code D8670 should be billed only when an adjustment to the appliances is provided and may not be billed before the date on which the orthodontic adjustment was performed. The number of visits for monthly adjustments to the appliances is restricted to the number that was authorized in the treatment plan. However, the number of monthly visits may be amended with appropriate documentation of medical necessity while the client is Medicaid eligible.

• Procedure code D8670 is paid only in conjunction with a history of braces (code D8080), unless special circumstances exist.

• All orthodontic procedure codes and appliances are global fees.

• Separate fees for adjustments to retainers are not payable.

• The appropriate procedure code should be billed for those appliances required as part of the treatment of cleft palate cases.

Special orthodontic appliances may also be used with full banding and crossbite therapy with approval by the TMHP Dental Director.

• Procedure codes D5951, D5952, D5953, D5954, D5955, D5958, D5959, and D5960 are to be used as applicable with documentation of medical necessity. Otherwise, use the appropriate special orthodontic appliance code.

• Full banding is allowed on permanent dentition only, and treatment should be accomplished in one stage and is allowed once per lifetime.

**Exception:** Cases of mixed dentition when the treatment plan includes extractions of remaining primary teeth or cleft palate.

• Crossbite therapy is allowed for primary, mixed, or permanent dentition.

• Providers must not request crossbite correction (limited orthodontics) for a mixed dentition client when there is a need for full banding in the adult teeth. Crossbite therapy is an inclusive charge for treating the crossbite to completion, and additional reimbursement is not provided for adjustments or maintenance.

• If a case is not approved, the dentist may file a claim for payment of the diagnostic workup for procedure codes used that were necessary to request the prior authorization (procedure codes D0330, D0340, D0350, and D0470). The dentist may receive payment under these procedure codes for no more than two cases out of every ten cases denied. The dentist should determine if the client’s condition meets orthodontic benefit criteria before performing a diagnostic workup.

• Procedure codes D8080, D8050, and D8060, are limited to one per lifetime.

• Comprehensive orthodontic services (procedure code D8080) are restricted to clients who are 12 years of age or older or clients who have exfoliated all primary dentition. Crossbite therapy includes diagnostic cast services.

**5.3.24.2 Completion of Treatment Plan**

If a client reaches 21 years of age or loses Medicaid eligibility before the authorized orthodontic treatment is completed, reimbursement is provided to complete the orthodontic treatment that was authorized and initiated while the client was 20 years of age or younger, eligible for Medicaid THSteps, and completed within 36 months. Any orthodontic-related service requested in the prior authorization request (e.g., extractions or surgeries) must be completed before the loss of client eligibility. Services cannot be added or approved after Medicaid THSteps eligibility has expired.

**Exception:** Medicaid will not reimburse for any orthodontic services during a period of time when a THSteps client is incarcerated. During a period of incarceration, the facility is responsible for any and all dental services, including orthodontic services.
5.3.24.3 Premature Removal of Appliances

The overall fee for orthodontic treatment (D8080) includes the removal of orthodontic brackets and treatment appliances. Procedure code D7997 may be used only when the appliances were placed by a different provider with an unaffiliated practice (not a partner or office-sharing arrangement) and one of the following conditions exist:

- There is documentation of a lack of cooperation from the client.
- The client requests premature removal and a release of liability form has been signed by the parent, guardian, or client if he is at least 18 years of age.

Providers must keep a copy of the release of liability form on file and are responsible for this documentation during a review process.

5.3.24.4 Transfer of Orthodontic Services

Prior authorization that has been issued to a dental provider for orthodontic services is not transferable to another dental provider. The new provider must submit to TMHP a new prior authorization request to get approval to complete the orthodontic treatment that was initiated by the original provider.

To complete the treatment plan, the client must be eligible for Medicaid with a current client Medicaid Identification Form (Form H3087) or Medicaid Eligibility Verification Form (Form H1027).

If the client does not return for the completion of services and there is documented failure to keep appointments by the client, the dental provider who initiated the services may submit a claim for reimbursement. The claim must be received by TMHP within the 95-day filing deadline from the last DOS.

The following supporting documentation must accompany the new request for orthodontic services and must include the DOS the orthodontic diagnostic tools were completed and include:

- All of the documentation as required for the original provider.
- The reason the client left the previous provider, if known.
- An explanation of the treatment status.
- A complete treatment plan addressing all procedures for which authorization is being requested (such as the number of monthly adjustments or retainers required to complete the case).
- A full diagnostic workup (procedure code D8080) with an HLD Index. The score of 26 points will be modified according to any progress achieved.

Exception: The prior authorization requests for clients who initiate orthodontic services before becoming eligible for Medicaid do not require models or the HLD score sheet, nor does the client have to meet the HLD Index of 26 points. However, a complete plan of treatment is required.

Note: If Medicaid clients initiate orthodontic services outside of Medicaid because they do not score 26 points on the HLD, they are not eligible to have their orthodontic services transferred to or reimbursed by Medicaid.

Providers who want to request prior authorization to complete orthodontic treatment that was initiated by another provider must complete a THSteps Dental Mandatory Prior Authorization Request Form and send it, the complete plan of treatment, and the appropriate documentation for orthodontic services or crossbite therapy to the TMHP Dental Director at the following address:

Texas Medicaid & Healthcare Partnership
THSteps Dental Prior Authorization Unit
PO Box 202917
Austin, TX 78720-2917
5.3.24.5 Comprehensive Orthodontic Treatment

Comprehensive orthodontic services (procedure code D8080) are restricted to clients who are 12 years of age or older or clients who have exfoliated all primary dentition.

National procedure codes do not allow for any work-in-progress or partial billing by separating the three orthodontic components: diagnostic workup, orthodontic appliance (upper), or orthodontic appliance (lower).

When billing for comprehensive orthodontic treatment, procedure code D8080, three local codes must be submitted as remarks codes along with procedure code D8080. Local codes (procedure codes Z2009, Diagnostic workup approved; Z2011, Orthodontic appliance, upper; or Z2012, Orthodontic appliance, lower) must be placed in the Remarks Code field on electronic claims or Block 35 on paper claims.

**Note:** If the remarks code and procedure code D8080 are not submitted, the claim will be denied.

Each remarks code pays the correct reimbursement rate which, when combined, totals the maximum payment of $775. Procedure code D8080 must be billed on three separate details, with the appropriate remarks code, even if billing for the workup and full banding. Billing only one detail for a total of $775 will not be accepted.

**Example 1:** A client is approved for full banding, but after the initial workup, the client discontinues treatment. This provider would bill the national procedure code D8080 and place the local code Z2009, Diagnostic workup approved, in the Remarks/comment field. The claim would pay $175.

**Example 2:** A client is approved for full banding. The provider continues treatment and places the maxillary bands. The provider would bill the national procedure code D8080 and place the local procedure code Z2009, Diagnostic workup approved, and Z2011, Maxillary bands, in the Remarks/comment field. The claim would pay $475.

All electronic claims for procedure code D8080 must have the appropriate remarks code associated with the procedure code.

Providers should adhere to the following guidelines for electronic claim submission so that TMHP can accurately apply the correct remarks code to the appropriate claim detail.

A Diagnostic Procedure Code (DPC) remarks code must be submitted, only once, in the first three bytes of the NTE02 at the 2400 loop.

**Example 1:** For a claim with one detail, submitted with procedure code D8080 and remarks code Z2009, enter the information as follows: DPCZ2009. The total billed would be $175.

**Example 2:** For a claim with two details, where details one and two are procedure code D8080 and the remarks codes are Z2009 and Z2011, enter the information as follows: DPCZ2009Z2011. The total billed would be $475.

**Example 3:** For a claim with three details, where all three details are submitted separately with procedure code D8080, enter the remarks code based on the order of the claim detail as follows: DPCZ2009Z2011Z2012. The total billed would be $775.

This method ensures accurate and appropriate payment for services rendered and addresses the need for partial billing.
5.3.24.6 Orthodontic Procedure Codes and Fee Schedule

When submitting claims for orthodontic procedures, use the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0330*, D0340*, D0350*, and D0470*</td>
<td>When requested orthodontic cases are submitted for authorization and denied, two out of ten denials will be paid. These four procedure codes, when billed together for denied cases, replace local procedure code Z2010.</td>
<td>$100.00</td>
</tr>
<tr>
<td>D7280</td>
<td>A 1-20</td>
<td>$62.50</td>
</tr>
</tbody>
</table>

**Orthodontic Services**

**Interceptive Orthodontic Treatment**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8050*</td>
<td>Replaces Z2018 and 8110D. Limited to one per lifetime.</td>
<td>$340.00</td>
</tr>
<tr>
<td>D8060*</td>
<td>Replaces Z2018 and 8120D. Limited to one per lifetime.</td>
<td>$340.00</td>
</tr>
</tbody>
</table>

**Comprehensive Orthodontic Treatment**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8080*</td>
<td>Replaces Z2009, Z2011, and Z2012. Limited to one per lifetime.</td>
<td>$775.00</td>
</tr>
</tbody>
</table>

**Minor Treatment to Control Harmful Habits**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8210*</td>
<td>Refer to Subsection 5.3.25, “Special Orthodontic Appliances” below for associated remarks field code.</td>
<td>See separate table</td>
</tr>
<tr>
<td>D8220*</td>
<td>Refer to Subsection 5.3.25, “Special Orthodontic Appliances” below for associated remarks field code.</td>
<td>See separate table</td>
</tr>
</tbody>
</table>

**Other Orthodontic Services**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8660*</td>
<td>Replaces Z2008. Denied when billed on the same DOS as D0120, D0145, or D0150.</td>
<td>$15.00</td>
</tr>
<tr>
<td>D8670*</td>
<td>Replaces Z2013.</td>
<td>$68.10</td>
</tr>
<tr>
<td>D8680*</td>
<td>Replaces Z2014 and Z2015; one retainer per arch per lifetime; may be replaced once because of loss or breakage (prior authorization is required).</td>
<td>$100.00</td>
</tr>
<tr>
<td>D8690*</td>
<td>Bracket replacement.</td>
<td>$20.00</td>
</tr>
<tr>
<td>D8691</td>
<td>Not considered medically necessary.</td>
<td>NC</td>
</tr>
<tr>
<td>D8692</td>
<td>Although procedure code D8692 is not a benefit of Texas Medicaid, providers can use procedure code D8680 to bill for retainer(s). Providers should include local code Z2014 or Z2015 on the claim form to indicate upper or lower, as appropriate.</td>
<td>NC</td>
</tr>
<tr>
<td>D8693</td>
<td></td>
<td>$50.00</td>
</tr>
<tr>
<td>D8999</td>
<td></td>
<td>Manually priced</td>
</tr>
</tbody>
</table>

* = Services payable to an FQHC for a client encounter.

5.3.25 Special Orthodontic Appliances

All removable or fixed special orthodontic appliances must be prior authorized. The prior authorization request must include both the national code and remarks code. However, prior authorization requests may omit the DPC prefix to the eight-digit remarks code.
All removable or fixed special orthodontic appliances must be billed with national procedure code D8210 or D8220. Dental models must be submitted when requesting prior authorization of a thumb-sucking or tongue thrust appliance. To ensure appropriate claims processing, the DPC remarks code (local procedure code) reflecting the specific service is also required. The appropriate remarks codes must be entered on the prior authorization request form. Failure to follow the following steps will cause the claims to deny. Failure to enter the DPC remarks code and the appropriate procedure code will not result in claim denial; however, manual intervention is required to process the claim, which may result in a delay of payment.

For paper claim submissions, providers must enter the local procedure code in Block 35 (Remarks) of the 2006 ADA claim form.

For electronic submissions, providers enter the DPC remarks code in the Comments field to ensure correct authorization, accurate records, and reimbursement.

For electronic submissions other than TexMedConnect submissions, providers must follow the steps below to ensure TMHP accurately applies the correct local procedure code to the appropriate claim detail:

11) The DPC prefix must be submitted, only once, in the first three bytes of the NTE02 at the 2400 loop.
12) In bytes 4-8, providers must submit the remark code (local procedure code) based on the order of the claim detail. Do not enter any spaces or punctuation between remark codes, unless to designate the detail is not billed with D8210 or D8220.

**Example:** For a claim with three details, where details one and three are submitted with procedure code D8210 and detail two is not, enter the following information in the NTE02 at the 2400 loop: DPC1014D 1046D. (The space shows that detail two needs no local code.) If all details require a local code, enter DPC, no spaces, and the appropriate local codes.

To submit using TexMedConnect, providers must enter the local code into the Remarks Code field, located under the details header. The Remarks Code field is the field directly after the Procedure Code field. TexMedConnect submitters are not required to manually enter the DPC prefix as it is placed in the appropriate field on the TexMedConnect electronic claim.

The following table identifies the appropriate DPC remarks codes to use when requesting prior authorization or billing for procedure code D8210 or D8220:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Remarks Code</th>
<th>Remarks Code Description</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8220*</td>
<td>DPC1000D</td>
<td>Appliance with horizontal projections</td>
<td>$250</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1001D</td>
<td>Appliance with recurved springs</td>
<td>$250</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1002D</td>
<td>Arch wires for crossbite correction (for total treatment)</td>
<td>$595</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1003D</td>
<td>Banded maxillary expansion appliance</td>
<td>$375</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1004D</td>
<td>Bite plate/bite plane</td>
<td>$100</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1005D</td>
<td>Bionator</td>
<td>$100</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1006D</td>
<td>Bite block</td>
<td>$250</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1007D</td>
<td>Bite-plate with push springs</td>
<td>$250</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1008D</td>
<td>Bonded expansion device</td>
<td>$225</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1010D</td>
<td>Chateau appliance (face mask, palatal exp and hawley)</td>
<td>$300</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1011D</td>
<td>Coffin spring appliance</td>
<td>$275</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1012D</td>
<td>Crib</td>
<td>$100</td>
</tr>
</tbody>
</table>

* = Services payable to an FQHC for a client encounter.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Remarks Code</th>
<th>Remarks Code Description</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8210*</td>
<td>DPC1013D</td>
<td>Dental obturator, definitive (obturator)</td>
<td>$250</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1014D</td>
<td>Dental obturator, surgical (obturator, surgical stayplate, immediate temporary obturator)</td>
<td>$250</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1015D</td>
<td>Distalizing appliance with springs</td>
<td>$250</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1016D</td>
<td>Expansion device</td>
<td>$375</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1017D</td>
<td>Face mask (protraction mask)</td>
<td>$350</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1018D</td>
<td>Fixed expansion appliance</td>
<td>$375</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1019D</td>
<td>Fixed lingual arch</td>
<td>$225</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1020D</td>
<td>Fixed mandibular holding arch</td>
<td>$100</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1021D</td>
<td>Fixed rapid palatal expander</td>
<td>$375</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1022D</td>
<td>Frankel appliance</td>
<td>$100</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1023D</td>
<td>Functional appliance for reduction of anterior openbite and crossbite</td>
<td>$375</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1024D</td>
<td>Headgear (face bow)</td>
<td>$150</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1025D</td>
<td>Herbst appliance (fixed or removable)</td>
<td>$250</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1026D</td>
<td>Inter-occlusal cast cap surgical splints</td>
<td>$375</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1027D</td>
<td>Intrusion arch</td>
<td>$100</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1028D</td>
<td>Jasper jumpers</td>
<td>$100</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1029D</td>
<td>Lingual appliance with hooks</td>
<td>$100</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1030D</td>
<td>Mandibular anterior bridge</td>
<td>$175</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1031D</td>
<td>Mandibular bihelix (similar to a quad helix for mandibular expansion to attempt nonextraction treatment)</td>
<td>$100</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1032D</td>
<td>Mandibular lip bumper</td>
<td>$100</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1036D</td>
<td>Mandibular lingual 6x6 arch wire</td>
<td>$100</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1037D</td>
<td>Mandibular removable expander with bite plane (crozat)</td>
<td>$275</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1038D</td>
<td>Mandibular ricketts rest position splint</td>
<td>$375</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1039D</td>
<td>Mandibular splint</td>
<td>$225</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1040D</td>
<td>Maxillary anterior bridge</td>
<td>$175</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1041D</td>
<td>Maxillary bite-opening appliance with anterior springs</td>
<td>$100</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1042D</td>
<td>Maxillary lingual arch with spurs</td>
<td>$100</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1043D</td>
<td>Maxillary and mandibular distalizing appliance</td>
<td>$100</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1044D</td>
<td>Maxillary quad helix with finger springs</td>
<td>$325</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1045D</td>
<td>Maxillary and mandibular retainer with pontics</td>
<td>$175</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1046D</td>
<td>Maxillary Schwarz</td>
<td>$250</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1047D</td>
<td>Maxillary splint</td>
<td>$225</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1048D</td>
<td>Mobile intraoral Arch-Mia (similar to a BiHelix for nonextraction treatment)</td>
<td>$100</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1049D</td>
<td>Modified quad helix appliance</td>
<td>$275</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1050D</td>
<td>Modified quad helix appliance (with appliance)</td>
<td>$275</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1051D</td>
<td>Nance appliance</td>
<td>$100</td>
</tr>
</tbody>
</table>

* = Services payable to an FQHC for a client encounter.
5.3.26 How to Score the Handicapping Labio-lingual Deviation (HLD) Index

The orthodontic provider must complete and sign the diagnosis (Angle class).

**Cleft Palate**
Reimbursement for a cleft palate case in the mixed dentition will be considered only if narrative justification supports treatment before the client reaches full dentation.

*Note:* Intermittent treatment requests may exceed the allowable 26 reimbursable treatment visits.

**Severe Traumatic Deviations**
Refers to facial accidents only. Points cannot be awarded for congenital deformity. Severe traumatic deviations do not include traumatic occlusions for crossbites.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Remarks Code</th>
<th>Remarks Code Description</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8220*</td>
<td>DPC1052D</td>
<td>Nasal stent</td>
<td>$250</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1053D</td>
<td>Occlusal orthotic device</td>
<td>$175</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1054D</td>
<td>Orthopedic appliance</td>
<td>$250</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1055D</td>
<td>Other mandibular utilities</td>
<td>$100</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1056D</td>
<td>Other maxillary utilities</td>
<td>$100</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1057D</td>
<td>Palatal bar</td>
<td>$225</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1058D</td>
<td>Post-surgical retainer</td>
<td>$125</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1059D</td>
<td>Quad helix appliance held with transpalatal arch horizontal projections</td>
<td>$275</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1060D</td>
<td>Quad helix maintainer</td>
<td>$275</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1061D</td>
<td>Rapid palatal expander (RPE), such as quad Helix, Haas, or Menne</td>
<td>$350</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1062D</td>
<td>Removable bite plate</td>
<td>$100</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1063D</td>
<td>Removable mandibular retainer</td>
<td>$100</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1064D</td>
<td>Removable maxillary retainer</td>
<td>$100</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1065D</td>
<td>Removable prosthesis</td>
<td>$175</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1066D</td>
<td>Sagittal appliance 2 way</td>
<td>$250</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1067D</td>
<td>Sagittal appliance 3 way</td>
<td>$350</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1068D</td>
<td>Stapled palatal expansion appliance</td>
<td>$375</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1069D</td>
<td>Surgical arch wires</td>
<td>$250</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1070D</td>
<td>Surgical splints (surgical stent/wafer)</td>
<td>$250</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1071D</td>
<td>Surgical stabilizing appliance</td>
<td>$250</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1072D</td>
<td>Thumbsucking appliance, requires submission of models</td>
<td>$175</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1073D</td>
<td>Tongue thrust appliance, requires submission of models</td>
<td>$100</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1074D</td>
<td>Tooth positioner (full maxillary and mandibular)</td>
<td>$325</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1075D</td>
<td>Tooth positioner with arch</td>
<td>$100</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1076D</td>
<td>Transpalatal arch</td>
<td>$100</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1077D</td>
<td>Two bands with transpalatal arch and horizontal projections forward</td>
<td>$175</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1078D</td>
<td>Appliance</td>
<td>$275</td>
</tr>
</tbody>
</table>

* = Services payable to an FQHC for a client encounter.
Overjet in Millimeters
Score the case exactly as measured. The measurement should be recorded from the most protrusive incisor, then subtract 2 mm (considered the norm), and enter the difference as the score.

Overbite in Millimeters
Score the case exactly as measured. The measurement should be recorded from the labio-incisal edge of the overlapped anterior tooth or teeth to the point of maximum coverage, then subtract 3 mm (considered the norm), and enter the difference as the score. This would be double-counting.

Mandibular Protrusion in Millimeters
Score the client exactly as measured. The measurement should be recorded from the "line of occlusion" of the permanent teeth, not from the ectopically erupted teeth in the anterior segment. Caution is advised in undertaking treatment of open bites in older teenagers because of the frequency of relapse.

Open Bite in Millimeters
Score the case exactly as measured. Measurement should be recorded from the line of occlusion of the permanent teeth, not from ectopically erupted teeth in the anterior segment. Caution is advised in undertaking treatment of open bites in older teenagers, because of the frequency of relapse.

Ectopic Eruption
An unusual pattern of eruption, such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge. Note: Record the more serious condition. Do not include (score) teeth from an arch if that arch is to be counted in the category of Anterior Crowding. For each arch, either the ectopic eruption or anterior crowding may be scored, but not both.

Anterior Crowding
Anterior teeth that require extractions as a prerequisite to gain adequate room to treat the case. If the arch expansion is to be implemented as an alternative to extraction, provide an estimated number of appointments required to attain adequate stabilization. Arch length insufficiency must exceed 3.5 mm to score for crowding on any arch. Mild rotations that may react favorably to stripping or moderate expansion procedures are not to be scored as crowded.

Labio-lingual Spread in Millimeters
The score for this category should be the total, in millimeters, of the anterior spaces.

Providers should be conservative in scoring. Liberal scoring will not be helpful in the evaluation and approval of the case. The case must be considered dysfunctional and have a minimum of 26 points on the HLD index to qualify for any orthodontic care other than crossbite correction. Half-mouth cases cannot be approved.

The intent of the program is to provide orthodontic care to clients with handicapping malocclusion to improve function. Although aesthetics is an important part of self-esteem, services that are primarily for aesthetics are not within the scope of benefits of this program.

The proposals for treatment services should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch will be reviewed for duplication of purpose.

If attaining a qualifying score of 26 points is uncertain, providers should include a brief narrative when submitting the case. The narrative may reduce the time necessary to gain final approval and reduce shipping costs incurred to resubmit records.

Providers must properly label and protect all records (especially plaster diagnostic models) when shipping. If plaster diagnostic models are requested by and shipped to TMHP, the provider should assure that the models are adequately protected from breakage during shipping. TMHP will return intact models to the provider.
5.3.26.1 HLD Score Sheet

This sheet and a Boley Gauge are required to score.

Procedure:

- Occlude client or models in centric position.
- Record all measurements rounded-off to the nearest millimeter.
- Enter a score of 0 if the condition is absent.

PLEASE PRINT CLEARLY:

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Date of birth:</th>
<th>Medicaid ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: (Street/City/County/State/ZIP Code)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONDITIONS OBSERVED</th>
<th>HLD SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleft Palate</td>
<td>Score 15</td>
</tr>
<tr>
<td>Severe Traumatic Deviations (Trauma/Accident related only)</td>
<td>Score 15</td>
</tr>
<tr>
<td>Overjet in mm. Minus 2 mm. Example: 8 mm. – 2 mm. = 6 points</td>
<td>=</td>
</tr>
<tr>
<td>Overbite in mm. Minus 3 mm. Example: 5 mm. – 3 mm. = 2 points</td>
<td>=</td>
</tr>
<tr>
<td>Mandibular Protrusion in mm. See definitions/instructions to score (previous page) x5</td>
<td>=</td>
</tr>
<tr>
<td>Open Bite in mm. See definitions/instructions to score (previous page) x4</td>
<td>=</td>
</tr>
<tr>
<td>Ectopic Eruption (Anteriors Only) Reminder: Points cannot be awarded on the same arch for Ectopic Eruption and Crowding</td>
<td>Each tooth x3 =</td>
</tr>
<tr>
<td>Anterior Crowding 10 point maximum total for both arches combined Max. Mand. = 5 pts. each arch</td>
<td>=</td>
</tr>
<tr>
<td>Labio-lingual Spread in mm.</td>
<td>=</td>
</tr>
<tr>
<td>TOTAL</td>
<td>=</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>For TMHP use only Authorization Number</td>
</tr>
</tbody>
</table>

Examiner: Recorder:

Provider’s Signature

Please submit this score sheet with records
5.3.27 Emergency and/or Trauma Related Services for All THSteps Clients and Clients 5 Months of Age or Younger

THSteps clients birth through 5 months of age are not eligible for routine dental checkups; however:

- They can be seen for emergency dental services by the dentist at any time for trauma, early childhood caries, or other oral health problems.
- They may be referred to a dentist by their primary care provider when a medical checkup identifies the medical necessity for dental services.

Prior authorization is not required for emergency or trauma-related dental services. Claims for these dental services must be filed separately from nonemergency dental services. Only one emergency or trauma-related dental claim per client, per day may be considered for reimbursement. Routine therapeutic procedures are not considered emergency or trauma-related procedures.

When billing for emergency or trauma-related dental services, the provider must:

- Enter the word “Emergency” or “Trauma” in the description field (Block 30) of the claim form (also enter a brief description of the Current Dental Terminology [CDT] procedure code used). Claims are subject to retrospective review. If no comments are indicated on the claim form, the payment may be recouped.
- If checking the Other Accident box, briefly describe in the Remarks field, Block 35 of the claim form, what caused the emergency or trauma.
- Check the appropriate box in Block 45, Treatment Resulting From, of the claim form (the options to check are Occupational Illness/Injury, Auto Accident, or Other Accident).

Documentation to support the diagnosis and treatment of trauma must be retained in the client’s record.

Note: Indicating Trauma in the description field allows the provider to be reimbursed for treatment on an emergency, continuing, and long-term basis without regard to periodicity, subject to the client’s eligibility and program limitations. An exception to periodicity for THSteps dental services is granted automatically for immediate treatment and any future follow-up treatment, as long as each claim submitted for payment is marked “Trauma” in the Description field, Block 30, and the original date of treatment or incident is referenced in the Remarks field, Block 35.


Subsection 4.1, “Medicaid Identification Form H3087” in Section 4, Client Eligibility (Vol. 1, General Information).


Subsection 5.3.10, “Medicaid Dental Benefits, Limitations, and Fee Schedule” of this handbook.

5.3.28 Emergency Services for Medicaid Clients 21 Years of Age or Older

Limited dental services are available for clients 21 years of age or older (not residing in an ICF-MR facility) whose dental diagnosis is secondary to and causally related to a life-threatening medical condition.

5.3.28.1 Long Term Care (LTC) Emergency Dental Services

The Department of Aging and Disability Services (DADS) provides a limited range of dental services for Medicaid-eligible residents of LTC facilities. All claims for dental services provided to LTC residents are submitted to DADS. For information, providers should contact the appropriate LTC facility or DADS at 1-512-438-2633.

5.3.28.2 Laboratory Requirements

Dental laboratories must be registered with TSBDE laboratories, and technicians must not be under restrictions imposed by TSBDE or a court.

5.3.29 Mandatory Prior Authorization

Mandatory prior authorization is required for consideration of reimbursement to dental providers who render the following services:

- Orthodontia
- Implants
- Fixed prosthetic services
- Dental general anesthesia
- A combination of inlays/onlays or permanent crowns in excess of four per client
- Procedure code D4276
- Procedure code D7272
- Procedure code D7472
- Limited dental services for clients 21 years of age or older (not residing in an ICF-MR facility) whose dental diagnosis is secondary to and causally related to a life-threatening medical condition
- Cone beam imaging

Approved orthodontic treatment plans must be initiated before the client’s loss of Medicaid eligibility and before the 21st birthday, and must be completed within 36 months of the authorization date. Authorization for other procedures is valid for up to 90 days.

To obtain prior authorization for implants and fixed prosthodontics, a prior authorization form together with documentation supporting medical necessity and appropriateness must be submitted. Required documentation includes, but is not limited to:

- The THSteps Dental Mandatory Prior Authorization Request Form.
- Appropriate pretreatment radiographs.
- Necessary radiographs of each involved tooth, such as periapical views. Panoramic films are inadequate to document caries.
- Documentation supporting that the mouth is free of disease; no untreated periodontal or endodontic disease, or rampant caries.
- Documentation supporting only one virgin abutment tooth; at least one tooth must require a crown unless a Maryland Bridge is being considered.
- Tooth Identification (TID) System noting only permanent teeth.
- Documentation supporting that a removable partial is not a viable option to fill the space between the teeth.
Prior authorization will not be given when films show two abutment teeth (virgin teeth do not require a crown, except for Maryland Bridge) or there is untreated periodontal or endodontic disease, or rampant caries which would contraindicate the treatment.


The prior authorization number is required on claims for processing. If the client is not eligible for Medicaid on the DOS or the claim is incomplete, it will affect reimbursement. Prior authorization is a condition for reimbursement; it is not a guarantee of payment.

Note: Post-treatment authorization will not be approved for codes that require mandatory prior authorization.

Refer to: Form CH.14, “THSteps Dental Mandatory Prior Authorization Request Form” in this handbook.

5.3.29.1 Cone Beam Imaging
Prior authorization is required for procedure codes D0360, D0362, and D0363.

Cone beam imaging is used to determine the best course of treatment for cleft palate repair, skeletal anomalies, post-trauma care, implanted or fixed prosthodontics, and orthodontic or orthognathic procedures. Cone beam imaging is limited to initial treatment planning, surgery, and postsurgical follow up.

To obtain prior authorization, a THSteps Dental Mandatory Prior Authorization Request Form must be submitted with documentation supporting medical necessity and appropriateness. Required documentation includes, but is not limited to, the following:

- Presenting conditions
- Medical necessity
- Status of the client’s treatment

5.3.29.2 General Anesthesia for Dental Treatment
Prior authorization is required for the use of general anesthesia while rendering treatment (to include the dental service fee, the anesthesia fee and facility fee), regardless of place of service. A client must meet the minimum requirement of 22 total points on the Criteria for Dental Therapy Under General Anesthesia form.

Refer to: Section 3.3.9.1, “Criteria for Dental Therapy Under General Anesthesia” on page 26 of this handbook.

In those areas of the state with Medicaid Managed Care, precertification or approval is required from the client’s health maintenance organization (HMO) for anesthesia and facility charges. It is the dental provider’s responsibility to obtain precertification from the client’s HMO or managed care plan for facility and general anesthesia services. A medical checkup prior to a dental procedure requiring general anesthesia is considered an exception to THSteps periodicity. A referral to the client’s primary care physician is not required. Prior authorization is available for exceptions to periodicity. Providers must include all appropriate supporting documentation with the submittal. The criteria for general anesthesia applies only to treatment of clients who are 20 years of age or younger or ICF-MR program clients.

5.3.29.3 Orthodontic Services
Prior authorization is required for all THSteps orthodontic services except for procedure code D8660. The prior authorization request must contain the DOS that the orthodontic diagnostic tools were produced. If the request is approved, the date that the records were produced is considered to be the date on which orthodontic treatment begins.
Refer to: Form CH.14, “THSteps Dental Mandatory Prior Authorization Request Form” in this handbook.

If orthodontic treatment is medically indicated, providers are responsible for obtaining prior authorization for a complete orthodontic treatment plan while the client is eligible for Medicaid and THSteps and 20 years of age or younger.

Submission of diagnostic casts are not required when requesting prior authorization for procedure codes D8050, D8060, or D8080.

Prior authorization is a condition of reimbursement; it is not a guarantee of payment.

Upon receipt of prior authorization of complete treatment plans, providers are to advise clients that they will be able to receive the approved treatment services (e.g. orthodontic adjustments, bracket replacements and retainers), even if they lose Medicaid eligibility or reach 21 years of age. Approved orthodontic treatment must be initiated before the loss of Medicaid eligibility and completed within 36 months of the authorization date, unless the client is incarcerated. Medicaid does not pay for any dental services, including orthodontic, while the client is incarcerated.

Note: Providers must submit all orthodontic services for Medicaid managed care clients following these guidelines. Claims for dental services provided to children in foster care must be filed with StarDent, the claims processor for Superior Health Plan. STAR and STAR+PLUS are not responsible for orthodontic services.

5.3.30 THSteps and ICF-MR Dental Prior Authorization

Submit claims, dental correspondence, and THSteps and ICF-MR prior authorization requests to the appropriate address listed in the table below:

<table>
<thead>
<tr>
<th>Correspondence</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA dental claim forms</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>PO Box 200555</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0555</td>
</tr>
<tr>
<td>All dental correspondence Prior authorization requests</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>THSteps and ICF-MR Dental Authorization</td>
</tr>
<tr>
<td></td>
<td>PO Box 202917</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-2917</td>
</tr>
</tbody>
</table>

5.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including dental services. Dental services are subject to retrospective review and recoupment if documentation does not support the service billed.

The provider must educate all staff members, including dentists, about the following documentation requirements and charting procedures:

- For THSteps and ICF-MR dental claims, providers are not required to submit preoperative and postoperative radiographs unless these are specifically requested by HHSC, the TMHP Dental Director, or are needed for prior authorization or pre-payment review.
- Documentation of all restorative, operative, crown and bridge, and fixed and removable prosthodontics procedures must support the services that were performed and must demonstrate medical necessity that meets the professional standards of health care that are recognized by TSBDE. Documentation must include appropriate pretreatment, pre cementation and post cementation radiographs, study models and working casts, laboratory prescriptions, and invoices. Document-
tation must include the correct DOS. A panoramic radiograph without additional bitewing radiographs is considered inadequate as a diagnostic tool for caries detection. OIG may retrospectively recoup payment if the documentation does not support the services billed.

- All documentation must be maintained in the client’s record for a period of five years to support the medical necessity at the time of any post-payment utilization review. All documentation, including radiographs, must be of diagnostic and appropriate quality.

- In any situation where radiographs are required but cannot be obtained, intraoral photographs must be in the chart.

- Any complications, unusual circumstances encountered, morbidity, and mortality must be entered as a complete narrative in the client’s record.

- A provider must maintain a minimum standard of care through appropriate and adequate records, including a current history, limited physical examination, diagnosis, treatment plan, and written informed consent as a reasonable and prudent dentist would maintain. These records, as well as the actual treatment, must be in compliance with all state statutes, the Dental Practice Act, and the TSBDE Rules.

- Documentation for endodontic therapy must include the following: the medical necessity, pretreatment, during treatment and post-treatment periapical radiographs, the final size of the file to which the canal was enlarged, and the type of filling material used. Any reason that the root canal may appear radiographically unacceptable must be entered in the chart. Endodontic therapy must be in compliance with the American Association of Endodontists quality assurance guidelines.

- Documentation for most periodontal services requires a six-point per tooth depth of pocket charting, a complete mouth series of periapical and bitewing radiographs, and any other narratives or supporting documentation consistent with the nationally accepted standards of care of the specialty of periodontics, and which conform to the minimum standard of care for periodontal treatment required of Texas dentists. A panoramic radiograph without additional bitewing or periapical radiographs is considered inadequate for diagnosis of periodontal problems.

- Documentation for surgical procedures requiring a definitive diagnosis for billing a specific CDT code necessitates that a pathology report and a written record of clinical observations be present in the chart, together with any appropriate radiographs, operative reports, and appropriate supporting documentation. All impactions, surgical extractions, and residual tooth root extractions require appropriate preoperative periapical and/or panoramic radiographs (subject to limitations) be present in the chart.

- Any documentation requirements or limitations not mentioned in this manual that are present in the CDT are applicable. The written documentation requirements or limitations in this manual supercede those in the CDT.

5.4.1 General Anesthesia

The dental provider is required to maintain the following documentation in the client’s dental record:

- The medical evaluation justifying the need for anesthesia
- Description of relevant behavior and reference scale
- Other relevant narratives justifying the need for general anesthesia
- Client’s demographics, including date of birth
- Relevant dental and medical history
- Dental radiographs, intraoral/perioral photography and/or diagram of dental pathology
- Proposed dental plan of care
• Consent signed by parent or guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained
• Completed Criteria for Dental Therapy Under General Anesthesia form
• The parent or guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist’s assessment of their child’s behavior
• Dentist’s attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand alone form

### 5.4.2 Orthodontic Services

Requests for orthodontic services must be accompanied by all of the following documentation:

• An orthodontic treatment plan. The treatment plan must include all procedures required to complete full treatment (e.g., extractions, orthognathic surgery, upper and lower appliance, monthly adjustments, anticipated bracket replacements, appliance removal if indicated, special orthodontic appliances). The treatment plan should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch are reviewed for duplication of purpose.
• Cephalometric radiograph with tracing models.
• Completed and scored HLD sheet with diagnosis of Angle class (26 points required for approval of non-cleft palate cases).
• Facial photographs.
• Full series of radiographs or a panoramic radiograph; diagnostic-quality films are required (copies are accepted and radiographs will not be returned to the provider).
• Any additional pertinent information as determined by the dentist or requested by TMHP’s Dental Director. Requests for crossbite therapy require properly trimmed models to be retained in the office and must demonstrate the following criteria:
  • Posterior teeth. Not end-to-end, but buccal cusp of upper teeth should be lingual to buccal cusp of lower teeth.
  • Anterior teeth. The incisal edge of upper should be lingual to the incisal of the opposing arch.

The dentist should be certain that radiographs, photographs, and other information are properly packaged to avoid damage. TMHP is not responsible for lost or damaged materials.

**Refer to:** Form CH.14, “THSteps Dental Mandatory Prior Authorization Request Form” in this handbook.

### 5.5 Utilization Review

HHSC or a designated entity may conduct utilization reviews through automated analysis of a provider’s pattern(s) of practice, including peer group analysis. Such analysis may result in a subsequent on-site utilization review. HHSC or its claims processing contractor may conduct utilization reviews at the direction of the Office of Inspector General (OIG), according to HHSC rules.

DSHS may also conduct dental utilization reviews of randomly selected THSteps dental providers. These reviews compare Medicaid dental services that have been reimbursed to a dental provider to the results of an oral examination of the client as conducted by DSHS regional dentists.

**Refer to:** 25 TAC, Chapter 33, Subchapter F for more information about utilization review.
5.6 Claims Filing and Reimbursement

5.6.1 Reimbursement
The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §§355.8085, 355.8441(11), and 355.455(b). See the applicable fee schedule on the TMHP website at www.tmhp.com. To request a hard copy of the fee schedule, call the TMHP Contact Center at 1-800-925-9126.

5.6.2 Third-Party Resources (TPR)
For THSteps and ICF-MR dental claims, TMHP is responsible for determining if a third party resource (TPR) exists and for recouping payment from the TPR.

When the client’s Medicaid Identification Form (Form H3087) shows a P in the TPR column indicating the presence of other health insurance, THSteps and ICF-MR dental providers are not required to pursue TPR. The P does not distinguish between medical or dental. Dental providers are to bill TMHP for reimbursement.

THSteps providers should not bill private insurance for dental services. THSteps and ICF-MR dental providers should file the claim directly to TMHP even if the provider knows that the client has private insurance. TMHP will reimburse the claim and pursue payment from any other TPR. If a recoupment is made from another payment resource, TMHP will make the appropriate post-payment reconciliation with the dental provider.


5.6.3 Billing After Loss of Eligibility
The Texas Medicaid 95-day filing deadline applies to all THSteps and ICF-MR dental services. If a client has lost Medicaid eligibility or turned 21 years of age, continue to file claims for services provided on the DOS the client was eligible. Indicate the actual DOS on the claim form, and enter the authorization number in the appropriate block on each claim filed.


5.6.4 Claims Information
Dental services must be submitted to TMHP in an approved electronic format or on the ADA Dental Claim Form. Providers may purchase ADA Dental claim forms from the vendor of their choice. TMHP does not supply the forms. A sample of the ADA Dental Claim form can be found on the ADA website at www.ada.org/prof/resources/topics/claimform.asp.

When completing an ADA Dental claim form, all required information must be included on the claim, as TMHP does not key information from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

All THSteps and ICF-MR claims must be received by TMHP within 95 days from each DOS and submitted to the following address:

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

Claims for emergency, orthodontic, or routine dental services must each be filed on separate forms. A claim submitted for either emergency or orthodontic services must be identified as such in Block 35 (Remarks) of the claim form.

A THSteps and ICF-MR dental provider cannot bill Texas Medicaid under his individual performing provider identifier for the services provided by one or more associate dentists practicing in his office as employees or independent contractors with specific employer-employee or contractual relationships.
All dentists providing services to Medicaid clients must enroll as THSteps dental providers regardless of employer relationships. The individual provider billing may be reimbursed into a single accounting office to maintain these described relationships.

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.

Providers should bill Texas Medicaid their usual and customary fees.

Claims for dental services provided to children in foster care must be filed with StarDent, the claims processor for Superior HealthPlan.

**Refer to:** Subsection 5.3.3.2, “Children in Foster Care” in this handbook.

Texas Medicaid cannot be billed by a provider for appointments missed by clients. A client with Medicaid cannot be billed for failure to keep an appointment. Only claims for actual services rendered are considered for payment.

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

Section 6, “Claims Filing” (Vol. 1, General Information)

Subsection 1.4.9, “Billing Clients” in Section 1, Provider Enrollment and Responsibilities (Vol. 1, General Information).

### 5.6.5 Claim Appeals

A claim denied because of age restrictions or other limitations listed in the Medicaid dental fee schedule may be considered for reimbursement on appeal when client medical necessity is provided to the TMHP Dental Director.

All denied claim appeals (see Section 7, Appeals in Vol. 1, General Information) must be submitted to TMHP with the exception of a request to waive late filing deadlines. TMHP does not have the authority to waive state or federal mandates regarding claim filing deadlines.

If, after all appeal processes at TMHP have been exhausted, the provider remains dissatisfied with TMHP’s decision concerning the appeal, the provider may file a complaint with the HHSC Claims Administrator Contract Management Unit.

**Refer to:** Subsection 7.3.1, “Administrative Claim Appeals” in Section 7, “Appeals” (Vol. 1, General Information).

**Note:** Providers must exhaust the appeals process with TMHP before filing a complaint to the HHSC Claims Administrator Contract Management Unit.

**Refer to:** Subsection 7.1.4, “Paper Appeals” in Section 7, “Appeals” (Vol. 1, General Information).

Providers may use one of three methods to appeal Medicaid claims to TMHP: telephone (AIS), paper, or electronic.

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

Certain claims must be appealed on paper; they cannot be appealed either electronically or by telephone.

**Refer to:** Subsection 7.1.1.2, “Disallowed Electronic Appeals” in Section 7, “Appeals” (Vol. 1, General Information) for information about appeals that may not be appealed electronically.

Subsection 7.1.2, “Automated Inquiry System Appeals” in Section 7, “Appeals” (Vol. 1, General Information) for information about claims that may not be appealed through AIS.
To appeal in writing:

If a claim cannot be appealed electronically or by telephone, appeal the claim on paper by completing the following steps:

1) Provide a copy of the R&S Report page where the claim is reported.
2) Circle one claim per R&S Report page.
3) Identify the information that was incorrectly provided and note the correct information that should be used to appeal the claim. If necessary, specify the reason for appealing the claim.
4) Attach radiographs or other necessary supporting documentation.
5) If available, attach a copy of the original claim. Claim copies are helpful when the appeal involves dental policy or procedure coding issues.
6) Do not copy supporting documentation on the opposite side of the R&S Report.
7) It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It is also recommended that paper documentation be sent via certified mail with a return receipt requested to establish TMHP’s receipt of the claim and the date the claim was received. The provider is urged to retain copies of multiple claim submissions if the Medicaid provider identifier is pending.

Note: 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.

8) Submit the paper appeal with supporting documentation and any radiographs and adjustment requests to the following address:

Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

To appeal by telephone:

1) Contact the Dental Line at 1-800-568-2460.
2) For each claim in question, have the R&S Report listing the claim and any supporting documents readily available.
3) Identify the claim submitted for appeal. The internal control number (ICN) will be requested.
4) Supply the information necessary to correct the claim, such as the missing tooth number or letter, the corrected procedure code, surface ID, or Medicaid number.

The appeal will appear as finalized or pending on the following week’s R&S Report.

Providers may also appeal electronically.

Electronic appeal submission is a method of submitting Texas Medicaid appeals using a personal computer (PC). The electronic appeals feature can be accessed directly through the TMHP EDI Gateway or by using TexMedConnect. For additional information, contact the TMHP EDI Help Desk at 1-888-863-3638.

Electronic appeals can increase accuracy of claims processing, resulting in a more efficient case flow to the provider:

- Download and printout capabilities help maintain audit trails for the provider.
- Appeal submission windows can be automatically filled in with electronic R&S Report information, thereby reducing data entry time.
5.6.6 Frequently Asked Questions About Dental Claims

Q Why is routine dental treatment not a benefit when performed at the same visit as an emergency visit?
A The following are reasons routine dental treatment is not a benefit when performed at the same visit as an emergency visit:

- The purpose of an emergency claim is to allow the provider to treat a true emergency without the concern that routine dental procedures may be denied.
- Medicaid program policy guidelines do not allow payment for both emergency and routine services to the same provider at the same visit. True emergency claims process through the audit system correctly when “emergency” is checked on either the paper or electronic claim and the Remarks or Narrative section of the claim form describes the nature of the emergency.

Q Why are some claims for oral exams and emergency exams on the same date for the same client denied?
A Medicaid program policy does not allow an initial oral exam and an emergency exam to be billed on the same DOS for the same client. An emergency exam performed by the same provider in the same six-month time period as an initial exam may be considered for reimbursement only when the claim for the emergency exam indicates it is an emergency and the emergency block is marked and the Remarks or Narrative section is completed. If the claim is not marked as an emergency, the claim will be denied.

Q How are orthodontic bracket replacements reimbursed? Can the client be charged for bracket replacements?
A The provider should use orthodontic procedure code D8690 to claim reimbursement for bracket replacement. Medical necessity must be documented in the client record. Payment is subject to retrospective review. The client with current Medicaid eligibility must not be charged for bracket replacement. If the provider charges the client erroneously, the provider must refund any amount paid by the client.

Q Why could an appeal of a denied claim take a long time?
A An appeal can take a long time if TMHP is required to research the denied claim and determine the reason the claim did not go through the system. For faster results, providers should submit appeals as soon as possible and not use the entire 120 days allowed to submit the appeal.

The following are guidelines on filing claims efficiently:

- Use R&S Report dates to track filed claims.
- File claims electronically through TMHP EDI. Electronic billing does not allow a claim with an incorrect date to be accepted and processed, which saves time for the provider submitting claims and TMHP in processing claims. Call 1-888-863-3638, for more information about TMHP EDI.
- File claims with the correct information included. Most denied claims result from the omission of dates, signature, or narrative, or incorrect ID numbers such as client Medicaid numbers or provider identifiers.

Q Why are only ten appeals allowed per call?
A There is a limit on appeals per call to allow all providers equal access.

Q Why do reimbursement checks sometimes take a long time to arrive?
A Reimbursement may be delayed if a provider fails to submit claims in a timely manner.

Q Does electronic billing result in delayed payment?
A No. Providers who bill electronically report faster results than billing on paper. Providers are encouraged to use TMHP EDI for claims submission.
The following are helpful hints to a more efficiently processed claim:

- Ensure the provider identifier is on all claims.
- Include the performing provider’s signature on all paper claims.
- Verify client eligibility for procedures.
- Verify if the procedure code requires a narrative on the claim; the narrative is for medical necessity.
- Include the required client information, including name, birth date, and client number.
- Dental auxiliary staff (i.e., the hygienist or the chairside assistant) cannot enroll in Texas Medicaid; therefore, they cannot bill Texas Medicaid. Any procedure performed by the auxiliary must be billed by the supervising dentist, using the dentist’s provider identifier.

### Billing Reminders:

- Procedure code D8660 is allowed at different age levels, per provider. If procedure code D8660 is billed within six months of procedure code D8080, procedure code D8080 will be reduced by the amount that was paid for procedure code D8660.
- Prior authorization is required with documentation of medical necessity when replacing lost or broken orthodontic retainers (procedure code D8680). Client’s may not be billed for covered services.
- Prior authorization of orthodontic services is nontransferable. If a client changes an orthodontic provider for any reason, or a provider ceases to be a Medicaid provider, the new orthodontic services provider must submit a separate request for prior authorization. The provider requesting and receiving authorization for the service also must perform the service and submit the claim. Codes listed on the authorization letters are the only codes considered for payment. All other codes billed are denied. Providing the authorization number on the submitted claim results in more efficient claims processing.
- General anesthesia (provided in the dentist office, ambulatory service clinic, and inpatient/outpatient hospital settings) does not require prior authorization, unless the client does not meet the minimum required points for general anesthesia in subsection 5.3.22.1, “Criteria for Dental Therapy Under General Anesthesia” in this handbook. All THSteps dental charts for dental general anesthesia are subject to retrospective, random review for compliance with the Criteria for Dental Therapy Under General Anesthesia and requirements for chart documentation.
- Providers must not bill a client unless a formal denial for the requested item/service has been issued by TMHP stating the service is not a benefit of Texas Medicaid and the client has signed the Client Acknowledgment Statement in advance of the service being provided for that specific item or service. A provider must not bill Medicaid clients if the provided service is a benefit of Texas Medicaid.

Refer to: Subsection 1.4.9.1, “Client Acknowledgment Statement” in Section 1, Provider Enrollment and Responsibilities (Vol. 1, General Information).

THSteps clients must receive:

- Dental services specified in the treatment plan that meet the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- Dental services free from abuse or harm from the provider or the provider’s staff.
- Only the treatment required to address documented medical necessity that meets professionally recognized standards of health care.
6. THSTEPS MEDICAL

6.1 THSteps Medical and Dental Administrative Information

6.1.1 Overview
This section describes the administrative requirements for THSteps, including provider requirements, client eligibility requirements, and billing and claims processing information. Providers needing additional information may call 1-800-757-5691 or refer to Appendix 4, “THSteps Quick Reference Guide” in this handbook for a more specific list of resources and telephone numbers. Providers may also contact the Texas Department of State Health Services (DSHS) THSteps Provider Relations staff located in DSHS regional offices by calling the appropriate regional office as listed in subsection A.6, “DSHS Health Service Region Contacts” in Appendix A, State and Federal Offices Communication Guide (Vol. 1, General Information).

In addition, THSteps has developed online educational modules to provide additional information about the program, components of the medical checkup, and other information. These modules provide free continuing education hours for a variety of providers. Providers do not have to be enrolled in THSteps. These courses may be accessed at www.txhealthsteps.com.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid’s comprehensive preventive child health service for individuals birth through 20 years of age. In Texas, EPSDT is known as THSteps. EPSDT was defined by federal law as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 legislation and includes periodic screening, vision, hearing, and dental preventive and treatment services. In addition, Section 1905(r)(5) of the Social Security Act (SSA) requires that any medically necessary health-care service listed in the Act be provided to THSteps clients even if the service is not available under the state’s Medicaid plan to the rest of the Medicaid population. A service is medically necessary when it corrects or ameliorates the client’s disability, physical or mental illness, or chronic condition. These additional services are available through the Comprehensive Care Program (CCP). CCP services are the diagnosis and treatment components of THSteps. For questions about coverage, providers can call CCP at 1-800-846-7470.

6.1.2 Statutory Requirements
Several specific legislative requirements affect THSteps and the providers participating in the program. These include, but are not limited to, the following:

- Newborn Screening, Health and Safety Code, Chapter 37.
- Subsection 4.5, “Parental Accompaniment” in Appendix D, Texas Health Steps Statutory State Requirements, to this handbook.
- Requirements for Reporting Abuse or Neglect, as outlined in subsection 1.4.1, “Compliance with Texas Family Code” in Section 1, Provider Enrollment and Responsibilities (Vol. 1, General Information).
- Early Childhood Intervention (ECI), 34 Code of Federal Regulations (CFR) Part 303; Chapter 73, Texas Human Resources Code, and Title 40 Texas Administrative Code (TAC), Chapter 108.
- Newborn Hearing Screening, Health and Safety Code, Chapter 47.
- Teen Confidentiality Issues. There are many state statutes that may affect consent to medical care for a minor, depending on the facts of the situation. Among the relevant statutes are Chapters 32, 33, 153, and 266 of the Texas Family Code. Providers may want to consult an attorney, their licensing board, or professional organization if guidance is needed or questions arise on matters of medical consent.

Refer to: Appendix 4, “Texas Health Steps Statutory State Requirements” of this handbook for more information.
6.1.3 Texas Vaccines for Children (TVFC) Program

For Medicaid clients who are birth through 18 years of age, the TVFC program provides free vaccines that are recommended according to the Recommended Childhood and Adolescent Immunization Schedule (Advisory Committee on Immunization Practices [ACIP], American Academy of Pediatrics [AAP], and the American Academy of Family Physicians [AAFP]). Medicaid does not reimburse for vaccines/toxoids that are available from TVFC. To obtain free vaccines for clients who are birth through 18 years of age, THSteps providers must enroll in TVFC at DSHS. Providers may not charge Texas Medicaid for the cost of the vaccines obtained from TVFC; however the administration fee, not to exceed $14.85, is considered for reimbursement.

When single antigen vaccine(s)/toxoid(s) or comparable antigen vaccine(s)/toxoid(s) are available for distribution through TVFC, but the provider chooses to use an ACIP-recommended product that is not distributed through TVFC, the vaccine/toxoid will not be covered; however, the administration fee will be considered.

Note: Administered vaccines/toxoids must be reported to DSHS. DSHS submits all vaccines/toxoids reported with parental consent to a centralized repository of immunization histories for clients younger than 18 years of age. This repository is known in Texas as ImmTrac.

For additional information about immunizations, providers can refer to the THSteps online educational module “Immunization” at www.txhealthsteps.com.

Refer to:
- Appendix B, “Immunizations” in this handbook.
- Form CH.29, “TVFC Provider Enrollment (3 Pages)” in Appendix A, THSteps Forms, of this handbook for more information about enrolling as a TVFC provider.

6.1.4 Vaccine Adverse Event Reporting System (VAERS)

The National Childhood Vaccine Injury Act (NCVIA) requires health-care providers to report:

- Any reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the Reportable Events Table that occurs within the specified time period after vaccination.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from www.dshs.state.tx.us/immunize/forms/vaers_table.pdf.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event.

6.1.5 Referrals for Medicaid-Covered Services

When a provider performing a checkup determines that a referral for diagnosis or treatment is necessary for a condition found during the medical checkup, that information must be discussed with the parents/guardians. A referral must be made to a provider who is qualified to perform the necessary diagnosis or treatment services. If the performing provider is competent to treat the condition found, a referral elsewhere is not necessary, unless it is to the primary care provider to assure continuity of care. Medicaid managed care clients must be referred to their designated primary care provider for further treatment or referral.

Providers that need assistance finding a specialist who accepts clients with Medicaid coverage can call the THSteps Hotline at 1-877-847-8377, or they can find one using the Online Provider Lookup on the TMHP website at www.tmhp.com.

Continuity of care is an important aspect of providing services and follow-up. Efforts should be made to determine that the appointment was kept and that the provider who received the referral has provided a diagnosis and recommendations for further care to the referring provider.
In addition to referrals for conditions discovered during a checkup or for specialized care, the following referrals may be used:

- **Case Management for Children and Pregnant Women (CPW).** CPW provides health-related case management services to eligible children and pregnant women. CPW services include assessing the needs of eligible clients, formulating a service plan, making referrals, problem-solving, advocacy, and follow-up regarding family and client needs. For more information about eligibility, see subsection 3.1.1, “Eligibility” in *Behavioral Health, Rehabilitation, and Case Management Services Handbook* (Vol. 2, Provider Handbooks). To make a referral, providers can call the THSteps Hotline at 1-877-847-8377 or a CPW case management provider in their area. A list of CPW providers can be found on the DSHS Case Management website at www.dshs.state.tx.us/caseman.

- **Hearing Services referrals.** If the hearing screening returns abnormal results, the client must be referred to a Texas Medicaid provider who is a licensed audiologist or physician who provides audiology services. Clients who are birth through 20 years of age must be referred to a Texas Medicaid provider who is an audiologist or physician who is experienced with the pediatric population and who offers auditory services.

- **Routine Dental Referrals.** Routine dental referrals are required at 3-month intervals for all clients who are 6 months of age through 35 months of age, based on their caries risk assessment. Routine dental referrals are then performed at 6-month intervals for clients who are 36 months of age through 20 years of age (see subsection 6.1.7, “THSteps Dental Services” in this handbook). When possible, clients should be referred to provider who has completed the required benefit education and is certified by the DSHS Oral Health Program to perform First Dental Home services. Clients who are birth through 5 months of age are not eligible for routine dental examinations.

- **Referrals for Dental Treatment.** If a THSteps medical provider identifies the medical necessity of dental services, the provider must refer the client to a THSteps dental provider. The THSteps medical provider can accomplish this by providing the parent/guardian a listing of THSteps dentists from the Online Provider Lookup. The parent/guardian can receive assistance in locating a THSteps dentist and assistance with scheduling of dental appointments by contacting the THSteps toll-free helpline at 1-877-847-8377. Clients who are birth through 5 months of age also can be seen for emergency dental services by the dentist at any time for trauma, early childhood caries or other oral health problems. Clients who are birth through 20 years of age may self-refer for dental care.

- **Emergency Dental Referrals.** If a medical checkup provider identifies an emergency need for dental services, such as bleeding, infection, or excessive pain, the client may be referred directly to a participating dental provider. Emergency dental services are covered at any time for all Medicaid clients who are birth through 20 years of age.

  **Note:** Assistance in coordinating dental referrals can be obtained from the THSteps Hotline at 1-877-847-8377 or the DSHS Regional THSteps Coordinator for the respective region (lists are provided in subsection A.6, “DSHS Health Service Region Contacts” in Appendix A, State and Federal Offices Communication Guide (Vol. 1, General Information)). In cases of both emergency and nonemergency dental services, clients have freedom of choice in selecting a dental provider who is participating in the THSteps Dental Program.

- **Family Planning and Genetic Services Referrals.** For people eligible for Medicaid needing genetic services or family planning services, a referral should be made. Information about Medicaid-covered genetic services is available in Section 4, “Genetic Services” in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (Vol. 2, Provider Handbooks) and information about family planning services is available in Section 3, “Medicaid Title XIX family planning services” in *Gynecological and Reproductive Health, Obstetrics, and Family Planning Services Handbook* (Vol. 2, Provider Handbooks). If a THSteps medical provider also provides family planning, the provider may inform clients that these services are available.
• **Early Childhood Intervention (ECI) Referrals.** Federal and state law requires providers to refer children within 2 business days of identification of a suspected developmental delay or disability to the local ECI program for children who are birth through 35 months of age. The provider may call the local ECI Program or the DARS Inquiries Line at 1-800-628-5115 to make referrals. Children who are 3 years of age or older with a suspected developmental delay or disability should be referred to the local school district.

• **Women, Infants, and Children (WIC) Referrals.** Clients who are birth through 5 years of age or who are pregnant are eligible for WIC and should be referred to WIC.

Refer to: Subsection 8.1, “Medicaid Managed Care” in Section 8, “Managed Care” (Vol. 1, General Information) for more information about referrals for providers in areas of the state covered by Medicaid Managed Care.

### 6.1.6 THSteps Medical Checkup Facilities

All THSteps medical checkup policies apply to checkups completed in a physician’s office, a health department, clinic setting, or in a mobile/satellite unit. Enrollment of a mobile/satellite unit must be under a physician or clinic name. Mobile units can be a van or any area away from the primary office and are considered extensions of that office and are not separate entities.

The physical setting must be appropriate so that all elements of the checkup can be completed. For specific information, review the periodicity schedules and narrative explaining the schedules.

### 6.1.7 THSteps Dental Services

Access to THSteps dental services is mandated by Texas Medicaid and provides reimbursement for the early detection and treatment of dental health problems, including oral health preventive services, for Medicaid clients from birth through 20 years of age. THSteps dental service standards are designed to meet federal regulations and to incorporate the recommendations of representatives of national and state dental professional groups.

OBRA of 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which federal financial participation (FFP) is available, regardless of the limitations of Texas Medicaid. This expansion is referred to as CCP.

Refer to: Section 3, “Medicaid Children’s Services (CCP)” in this handbook for more information.

### 6.1.7.1 How the THSteps Dental Program Works

THSteps-designated staff (HHSC, DSHS, or its designee), through outreach and education, encourage the parents or caregivers of eligible clients to use THSteps dental checkups and preventive care when clients first become eligible for Medicaid and each time clients are due for their next periodic dental checkup.

Upon request, THSteps-designated staff (HHSC, DSHS, or its designee) assist the parents or caregivers of eligible clients with scheduling appointments and transportation. Medicaid clients have freedom of choice of providers and are given names of enrolled providers. Call the THSteps Hotline at 1-877-847-8377 for a list of THSteps dental providers in a specific area.

When a client is due for a THSteps periodic dental checkup, a message is present on the Medicaid Identification Form (H3087 or H3087 STAR) under the client’s name to remind the parent or guardian. If the client or caregiver believes the client is due for a dental checkup and a message is not present, the provider may contact TMHP through the TMHP website at www.tmhp.com or AIS at 1-800-925-9126 to verify that the client is due for a dental checkup.

Clients may be referred to a dental home provider beginning at 6 months of age to establish a dental home. Clients from 6 months of age through 35 months of age may be seen at 3-month intervals based on their caries risk assessment and at 6-month intervals thereafter through 20 years of age. Clients may
be referred to a dental provider beginning at 6 months of age or at any age if the medical checkup identifies medical necessity.

All THSteps clients who are birth through 20 years of age can be seen by the dentist at any time for emergency dental services for trauma, early childhood caries (ECCs), or any other appropriate dental or therapeutic procedure.

Clients who are birth through 20 years of age may self-refer for dental services.

**Note:** Clients enrolled in Medicaid Managed Care are required to choose a medical provider in their health plan’s network. The health plan does not reimburse for services rendered by nonparticipating providers. Please contact the specific health plan for enrollment information.

For additional information about dental health, providers can refer to the THSteps online educational modules “Dental Health For Primary Care Providers” and “Dental Screening by Dental Professionals” at www.txhealthsteps.com.

### 6.2 Enrollment

#### 6.2.1 THSteps Medical Provider Enrollment

Providers cannot be enrolled if their professional license is due to expire within 30 days of application. Facility providers must submit a current copy of the supervising practitioner’s license. To provide Medicaid services, each nurse practitioner (NP) must be licensed as a registered nurse (RN) and recognized as an advanced practice registered nurse (APRN) by the Texas Board of Nursing (BON).

To provide THSteps medical checkups, providers must be enrolled in Texas Medicaid and must be one of the following:

- A physician (doctor of medicine [MD] and doctor of osteopathy [DO]) who is currently licensed in the state where the service is provided
- A rural health clinic (RHCs) or Federally Qualified Health Center (FQHC)
- A health-care provider or facility (public or private) that is capable of performing the required medical checkup procedures under a physician’s direction, such as a regional or local health department, family planning clinic, migrant health clinic, community-based hospital or clinic, maternity clinic, home health agency, or school district. In the case of a clinic, a physician is not required to be present in the clinic at all times during the hours of operation; however, a physician must assume responsibility for the clinic’s operation.
- An APRN who is recognized by the Texas BON and nationally certified in at least one of the following:
  - Pediatrics
  - Family practice
  - Adult health (adolescents only)
  - Women’s health (adolescent females only)
  - Certified nurse midwife (newborns and adolescent females only)
- Physician assistants (PAs)—It is recommended that PAs have expertise or additional education in the areas of comprehensive pediatric assessment.

Residents may provide medical checkups in a teaching facility under the personal guidance of the attending staff as long as the facility’s medical staff by-laws and requirements of the Graduate Medical Education (GME) Program are met, and the attending physician has determined the intern or resident to be competent in performing these functions. THSteps does not require the supervising physician to examine the client as long as these conditions are met.
An RN without an advance practice certification may not enroll independently, but may perform THSteps medical checkups only under the supervision of a physician. The physician ensures that the RN has appropriate training and adequate skills for performing the procedures for which they are responsible.

Refer to: Subsection 1.1, “Provider Enrollment” in Section 1, Provider Enrollment and Responsibilities (Vol. 1, General Information) for information about enrollment procedures.

6.2.1.1 Additional Education Requirements for Registered Nurses (RNs)

The educational requirements have changed for RNs who complete the physical assessment portion of the THSteps medical checkup.

THSteps has developed online education modules that contain new courses approved for continuing education units (CEU) for RNs and must be completed prior to providing checkups. THSteps online education modules may be accessed at www.txhealthsteps.com.

Before a physician delegates a THSteps checkup to an RN, the physician must establish the RN’s competency to perform the service as required by the physician’s scope of practice. The delegating physician is responsible for supervising the RN who performs the services. The delegating physician remains responsible for any service provided to a client.

The RN or the employer must maintain documentation that the available required courses were completed, including the following:

- Overview
- Adolescent Health Screening
- Case Management Services in Texas
- Cultural Competence
- Oral Health for Primary Care Providers
- Developmental Screening
- Immunization
- Introduction to the Medical Home
- Mental Health Screening
- Newborn Hearing Screening
- Newborn Screening
- Nutrition
- Hearing and Vision Screening
- Weight Management

RNs who have completed the previously required courses are encouraged, but not required, to take the online courses.

Refer to: Subsection 6.2.1, “THSteps Medical Provider Enrollment” in this handbook for more information about enrollment procedures.

6.2.1.2 Medicaid Managed Care Enrollment

The Medicaid Managed Care program consists of two types of health-care delivery systems: Primary Care Case Management (PCCM) and health maintenance organizations (HMOs).
Clients enrolled in PCCM receive both THSteps medical and dental checkup services. PCCM clients may call 1-877-847-8377 to seek assistance in finding a THSteps provider. THSteps medical providers do not have to enroll with PCCM to be reimbursed for THSteps medical checkup services provided to PCCM clients, although coordination with the client's primary care provider is required.

Medicaid HMOs in the STAR and STAR+PLUS programs provide medical checkup services to their members. The Medicaid HMO in the STAR Health program provides both medical and dental checkups to its members. Medicaid HMO clients should check with their HMO to see whether they must select a provider in the network for THSteps checkups prior to receiving the services. Medicaid HMO providers must meet contractual obligations established by their respective HMOs with regards to providing medical checkups to THSteps clients. Medicaid HMO providers are reimbursed for THSteps medical checkup services through their HMO.

THSteps providers should encourage clients to see their primary care provider as their medical home. If the client's primary care provider is not a THSteps medical provider, the checkup provider should send the primary care provider the records from all THSteps medical checkups performed for the client.

All primary care providers are encouraged to enroll as THSteps medical providers. This allows the client to receive both acute care services and preventive THSteps services from the same provider.

Refer to: Section 8, Managed Care (Vol. 1, General Information).

6.3 Services/Benefits, Limitations, and Prior Authorization

6.3.1 THSteps Medical Checkups

Preventive care medical checkups (checkups) are a benefit of the THSteps program if they are provided by enrolled THSteps providers and all of the required components are completed. An incomplete periodic medical checkup is not a benefit. The THSteps periodicity schedule specifies screening procedures recommended at each stage of the client’s life to ensure that health screenings occur at age-appropriate points in a client’s life.

To receive services, the client must be eligible to receive Medicaid services and must be birth through 20 years of age at the time services are delivered. When a client turns 21 years of age after the first of a month, the client remains eligible for a checkup through the end of that month.

Components of a medical checkup that have an available Current Procedural Terminology (CPT) code are not reimbursed separately on the same day as a medical checkup, with the exception of developmental and autism screening.

Reminder: Incomplete medical checkups are subject to recoupment unless there is documentation supporting why a component was not completed.

Sports physical examinations are not a benefit of Texas Medicaid. If the client is due for a THSteps medical checkup and a comprehensive medical checkup is completed, a THSteps medical checkup may be reimbursed and the provider may complete the documentation for the sports physical.

Refer to: Subsection 6.3.1.9, “THSteps Medical Checkups Periodicity Schedule” in this handbook for information about the components required at specific ages.

Checkups should be scheduled, to the extent possible, based on the ages on the periodicity schedule to accommodate the need for flexibility when scheduling checkup appointments. A periodic age range is available with 11 billable visits possible in the first two years of the client’s life.

All of the checkups listed on the periodicity schedule were developed according to the recommendations of the AAP and in consultation with recognized authorities in pediatric preventive health. In Texas, THSteps has modified the AAP periodicity schedule based on the scheduling of laboratory or other tests in federal EPSDT or state regulations.
If the provider that performs the medical checkup provides treatment for an identified condition on the same day, the provider may submit a separate claim for an acute-care established-client office visit. The separate claim must include the established-client procedure code that is appropriate for the diagnosis and treatment of the identified problem. Treatment of minor illnesses or conditions (e.g., follow-up of a mild upper respiratory infection) during the THSteps medical checkup may not warrant additional billing.

Medicaid managed care (including PCCM) clients must be referred to their designated primary care provider for further treatment or referral if they are receiving a THSteps checkup outside the medical home. For more information about conducting a THSteps checkup, providers can refer to the THSteps online educational modules at www.txhealthsteps.com.

6.3.1.1 Medical Home Concept

Texas Medicaid defines a medical home as a model of delivering care that is accessible, continuous, comprehensive, family-centered, and coordinated. HHSC and DSHS encourage the provision of the THSteps medical checkup as part of a medical home.

For additional information on the medical home, providers can refer to the “Medical Home” module provided by THSteps at www.txhealthsteps.com.

6.3.1.2 Mobile Units and the Medical Home

Medical checkup providers with mobile units should encourage the families to establish a medical home for their child(ren) and obtain future checkups from their primary care provider. If the mobile unit is not the primary care provider, the mobile unit must also send the primary care provider the records from the medical checkup.

6.3.1.3 Eligibility for a Medical Checkup

Through outreach, THSteps staff (DSHS, HHSC, or contractors) encourage clients to use THSteps preventive medical checkup services when they first become eligible for Medicaid and each time thereafter when they are periodically due for their next medical checkup.

Providers are encouraged to perform checkups on any client they identify as eligible for medical checkups. They also are encouraged to notify clients when they are due for the next checkup according to the THSteps periodicity schedule.

A THSteps statement under the client’s name on the regular client Medicaid Identification (Form H3087) and the STAR Identification (Form H3087 STAR) indicates the THSteps services for which the client is currently eligible. A check mark on the identification form indicates eligibility for the particular service, such as eye exam, eye glasses, hearing aid, dental, prescriptions, and medical services. A blank space denotes that the client is not eligible for the particular service based on available data.

Client eligibility for a medical checkup is determined by the client’s age on the first day of the month. If a client’s birthday is not on the first of a month, the new eligibility period begins on the first day of the following month. If a client turns 21 years of age during a month, the client continues to be eligible for THSteps services through the end of that month.

Checkups that are necessary when a THSteps statement does not indicate a medical checkup is due must be billed as an exception to the periodicity checkup.

Refer to: Subsection 6.3.1.6, “Exception-to-Periodicity Checkups” in this handbook for additional details about billing for a checkup performed as an exception-to-periodicity checkup.

Although the Medicaid Eligibility Verification Letter (Form H1027) identifies eligible clients when the client Form H3087 is lost or has not yet been issued, Form H1027 does not indicate periodic eligibility for medical checkup services. Providers can call the TMHP Contact Center at 1-800-925-9126 or check the TMHP website at www.tmhp.com to verify a client’s eligibility for medical checkup services.
6.3.1.4 Verification of Medical Checkups

The first source of verification that a THSteps medical checkup has occurred is a paid claim or encounter. THSteps encourages providers to file a claim either electronically or on a CMS-1500 claim form as soon as possible after the date of service (DOS), as the paid claim updates client information, including the Medicaid Identification (Form H0387).

A second source of acceptable verification is a physician’s written statement that the checkup occurred. If the provider chooses to give the client written verification, it must include the client’s name, Medicaid ID number, date of the medical checkup, and a notation that a complete THSteps medical checkup was performed.

**Note:** Verification of medical checkups must not be sent to THSteps but must be maintained by the client to be provided as needed by an HHSC eligibility caseworker.

If neither the first nor the secondary source of verification is available, a THSteps outreach worker may contact the provider’s office for verification.

6.3.1.5 Follow-up Medical Visit

Use procedure code 99211 with the THSteps provider identifier and THSteps benefit code when billing for a follow-up visit.

A return visit to follow up may be required to complete necessary procedures related to a THSteps medical checkup or exception-to-periodicity checkup, such as:

- Reading the tuberculosis (TB) skin test.
- Transportation and outreach work required by the provider for verification of a presumptive TB skin test.
- Administering immunizations in cases where the client’s immunizations were not up-to-date or medically contraindicated on the initial visit.
- Collection of specimens for laboratory testing that were not obtained during the original THSteps medical checkup or the original specimen cannot be processed.
- Completing sensory or developmental screening that was not completed at the time of the THSteps medical checkup due to the client’s condition.

**Note:** If the parent/guardian did not give consent for a component, then no follow-up visit is necessary.

A return visit to follow up on treatment initiated during a checkup or to make a referral is not a follow-up visit but is considered an acute care visit under an appropriate evaluation and management (E/M) procedure code for an established patient.

6.3.1.6 Exception-to-Periodicity Checkups

Exception-to-periodicity checkups are complete medical checkups completed outside the timeframes listed in the periodicity schedule due to extenuating circumstances. A THSteps medical checkup is allowed outside of the regular THSteps Periodicity Schedule (exception to periodicity) when:

- Medically necessary, for example, for a client with developmental delay, suspected abuse, or other medical concerns or a client in a high-risk environment, such as living with a sibling with elevated blood lead.
- Required to meet state or federal exam requirements for Head Start, day care, foster care, or preadoption.
- Immediately before a dental procedure requiring general anesthesia.
• The client will not be available at the time the next checkup is due, such as the case with clients
whose parents are migrant farm workers.

• If the provider is aware that the client is not due for a checkup based on age and the date of the last
checkup or the Medical Identification Form H3087 does not state that the client is due, the visit must
be submitted as an exception to periodicity.

When billing for an exception-to-periodicity visit, provider must also include the most appropriate
exception-to-periodicity modifiers. Claims for periodic THSteps medical checkups exceeding periodic-
ity that do not include one for these modifiers will be denied as exceeding periodicity.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>Medically necessary service or supply</td>
</tr>
<tr>
<td>23</td>
<td>Unusual Anesthesia: Occasionally, a procedure that usually requires either no anesthesia or local anesthesia must be done under general anesthesia because of unusual circumstances. This circumstance may be reported by adding the modifier “-23” to the procedure code of the basic service or by use of the separate 5-digit modifier code 09923.</td>
</tr>
<tr>
<td>32</td>
<td>Mandated Services: Services related to mandated consultation and/or related services (e.g., 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 5-digit modifier code 09932.</td>
</tr>
</tbody>
</table>

Refer to: Subsection 6.5, “CMS-1500 Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information) for billing instructions.

THSteps medical exception-to-periodicity services must be billed with the same procedure codes, provider type, modifier, and condition indicators as a medical checkup. Additionally, providers must use modifiers 23, 32, and SC to indicate the exception.

6.3.1.7 Medical Checkups for Infants, Children, and Adolescents (Birth Through 20 Years of Age)

The following information gives descriptions and requirements for each pediatric assessment and test
that must be performed during a THSteps medical checkup in accordance with the periodicity schedule. The checkup includes face-to-face contact with the client’s parents or guardians.

Refer to: Subsection 6.3.1.9, “THSteps Medical Checkups Periodicity Schedule” in this handbook.

The expected required components of a medical checkup must be age-appropriate and include the following:

• Comprehensive health history
• Comprehensive unclothed physical examination, including graphic recording of:
  • Height/length and weight
  • Body mass index (BMI) calculated beginning at 2 years of age
  • Fronto-occipital circumference through the first 24 months of age
• Blood pressure beginning at 3 years of age
• Nutritional screening
• Developmental screening
• Mental health screening
• Sensory screening
  • Vision screening
  • Hearing screening
• Tuberculosis screening
• Laboratory testing
  • Anemia screening
  • Lead screening
  • Age-appropriate laboratory testing
  • Risk-based laboratory testing
• Immunizations
  • Status
  • Administration, as necessary
• Dental referral
• Anticipatory guidance

The following table includes the procedure codes for checkups and the referral and condition indicators. Condition indicators must be used to describe the results of a checkup. A condition indicator must be submitted on the claim with the periodic medical checkup visit procedure code. Indicators are required whether a referral was made or not. If a referral is made, then providers must use the Y referral indicator. If no referral is made, then providers must use the N referral indicator. A checkup must be submitted with diagnosis code V202.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Referral Indicator</th>
<th>Condition Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381, 99382, 99383, 99384, and 99385 (new client preventive visit) or 99391, 99392, 99393, 99394, and 99395 (established client preventive visit)</td>
<td>N (no referral given)</td>
<td>NU (not used)</td>
</tr>
<tr>
<td>99381, 99382, 99383, 99384, and 99385 (new client preventive visit) or 99391, 99392, 99393, 99394, and 99395 (established client preventive visit)</td>
<td>Y (yes THSteps or EPSDT referral was given to the client)</td>
<td>S2 (under treatment) or ST* (new services requested)</td>
</tr>
</tbody>
</table>

*The ST condition indicator should only be used when a referral is made to another provider or the client must be rescheduled for another appointment with the same provider. It does not include treatment initiated at the time of the checkup.

When performed for a THSteps preventive care medical checkup, procedure codes 99385 and 99395 are restricted to clients who are 18 through 20 years of age.
Modifier AM, SA, TD, or U7 must be submitted with the THSteps medical checkups procedure code to indicate the practitioner who performed the unclothed physical examination during the medical checkup.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Physician, team member service</td>
</tr>
<tr>
<td>SA</td>
<td>Nurse practitioner rendering service in collaboration with a physician</td>
</tr>
<tr>
<td>TD</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>U7</td>
<td>Physician assistant</td>
</tr>
</tbody>
</table>

THSteps medical checkups performed in an FQHC or RHC setting are paid an all-inclusive rate per encounter. When submitting claims for THSteps checkups and services, RHC providers must use the national place-of-service (POS) code 72, and FQHC providers must use modifier EP in addition to the modifiers used to identify who performed the medical checkup. RNs in an RHC or FQHC may not perform THSteps checkups independently of a physician’s interactions with the client.

Refer to: Section 3, “Federally Qualified Health Center” in Outpatient Services Handbook (Vol. 2, Provider Handbooks) for information related to billing.

Section 5, “Rural Health Clinic” in Outpatient Services Handbook (Vol. 2, Provider Handbooks) for information related to billing.

Checkups, exception-to-periodicity checkups, and follow-up visits are limited to once per day any provider.

A checkup and the associated follow-up visit may not be reimbursed on the same date of service. The follow-up visit will be denied.

An incomplete checkup is subject to recoupment unless there is documentation to support why the component was not completed as part of the checkup.

A new patient is one who has not received any professional services within the preceding 3 years from the provider or from another provider of the same specialty who belongs to the same group practice. As an exception, a new preventive care medical checkup (procedure code 99381, 99382, 99383, 99384, or 99385) may be billed when no prior checkups have been billed by the same provider or provider group, even if an acute care new patient E/M service was previously performed by the same provider.

An additional new checkup is allowed only when the client has not received any professional services in the preceding 3 years from the same provider or another provider who belongs to the same group practice, because subsequent acute care visits to the new patient THSteps checkup continues the established relationship with the provider.

6.3.1.7.1 Acute Care Visits

If a new patient checkup has been billed within the preceding 3 years, subsequent checkups and acute care visits billed as new patient services will be denied when billed by the same provider or provider group.

For a client that is a new patient, an acute care visit and checkup visit may be reimbursed on the same date of service by the same provider or group. The checkup visit must be billed as a new patient checkup and the acute care visit as an established visit.

Providers must use modifier 25 to describe circumstances in which an acute care E/M visit was provided at the same time as a checkup. Providers must submit modifier 25 with the E/M procedure code when the rendered services are distinct and provided for a different diagnosis. Providers must bill an appro-
appropriate level E/M procedure code with the diagnosis that supports the acute care visit. The medical record must contain documentation that supports the medical necessity and the level of service of the E/M procedure code that is submitted for reimbursement.

An acute care E/M visit for an insignificant or trivial problem or abnormality billed on the same date of service as a checkup or exception-to-periodicity checkup is subject to recoupment.

6.3.1.8 Newborn Examination

Providers do not have to be enrolled as THSteps providers to bill newborn examination procedure codes 99460, 99461, 99462, and 99463.

Newborn examinations that are billed with procedure code 99460 or 99461 may be counted as a THSteps medical checkup when all required components are completed and documented in the medical record.

If a brief newborn examination is performed that does not fulfill THSteps medical checkup criteria, providers may bill procedure code 99460 or 99461 with modifier 52, which does not count as a THSteps visit.

Providers must use their Medicaid provider identifier when billing newborn examination services.

To qualify as a THSteps checkup, the initial newborn examination must meet the THSteps periodicity requirements and must include the appropriate required documentation.

Note: In Texas, the mandated newborn hearing screening and newborn screening test is included as part of the in-hospital newborn exam.

Providers billing these newborn codes are not required to be THSteps providers, but they must be enrolled as Medicaid providers. TMHP encourages THSteps enrollment for all providers that offer a medical home for clients and provide them with medical checkups and immunizations. Physicians and hospital staff are encouraged to inform parents eligible for Medicaid that the next THSteps checkup on the periodicity schedule should be scheduled at 3 to 5 days of age and that regular checkups should be scheduled during the first year.

Refer to: Subsection 6.3.38, “Newborn Services” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for additional information on inpatient newborn services.

THSteps online education module “Newborn Hearing Screening” on the THSteps website at www.txhealthsteps.com for additional information about conducting a newborn hearing screen.

6.3.1.9 THSteps Medical Checkups Periodicity Schedule

The client is periodically eligible for medical checkup services based on the THSteps medical checkups periodicity schedule. All the checkups listed on the periodicity schedule have been developed based on recommendations of the AAP and recognized authorities in pediatric preventive health. In Texas THSteps has modified the AAP periodicity schedule based on the scheduling of a laboratory or other test in federal EPSDT or state regulations.
THSteps Medical Checkups Periodicity Schedule for Infants, Children, and Adolescents (Birth Through 20 Years of Age)

The columns across the top of the schedule indicate the age a client is periodically eligible for a medical checkup. The first column on the left of the chart identifies each procedure that must be performed at each appropriate age. (See Key at bottom of page and Footnotes on the following page.)

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Key
* Required, unless medically contraindicated or because of parent’s reasons of conscience including a religious belief or the dated results obtained within the previous month documented on the health record.
✓ Required as above, unless already provided on a previous checkup at the required age, or the dated results obtained within the previous month, and documented on the health record with the date of service.
† If answers on risk assessment questionnaires or other screening show a risk factor, further screening is required. Refer to Footnotes for more information about marked items.
S Standardized screening tool must be used at these ages.

Effective 09/01/2009/Revised 04/05/2010
Footnotes

1. An age-appropriate, complete, unclothed physical exam is required at each checkup. For adolescents who are sexually active, a pelvic exam should be part of the examination.
2. Developmental screening is a required component of each checkup for clients, birth through 6 years of age. Checkups at 9, 12, 18, 24, and 30 months, 3 and 4 years of age require the use of a standardized screening tool of the provider's choice. The Ages and Stages Questionnaire (ASQ) or ASQ SE, PEDS screening tool may be used and may be submitted for separate reimbursement. If other screening tools are used, the provider may not submit for reimbursement. Checkups at 18 months also require a standardized screening tool for autism. The Modified Checklist for Autism in Toddlers (MCHAT) is one tool that may be used and is the only tool for autism that may be reimbursed. A standardized screen is not required for checkups at other ages listed on the THSteps Periodicity Schedule; however, developmental screening is required at these visits and includes a review of milestones (gross and fine motor skills; communication skills, speech-language development; self help/care skills; social, emotional, and cognitive development; and mental health).
3. Sensory screening:
   a. Vision:
      - Birth through 2 years of age—Screening includes history of high-risk conditions, observation, and physical examination.
      - Ages 3, 4, 5, 6, 8, 10, 12, 15, and 18 years of age—Screening includes administration of an age-appropriate vision chart.
      - Documentation of test results from a school vision screening program may be used if conducted within 12 months of the checkup.
   b. Hearing:
      - Birth through 3 years of age—Screening includes history, observation, and screening by use of the Parent Hearing Questionnaire.
      - Ages 4, 5, 6, 8, 10 year of age—A puretone audiometer must be used to screen hearing at checkups. Subjective screening may be completed at all other checkups.
      - Documentation of results from a school audiometric screening program may be used if conducted within 12 months of the checkup.
4. In areas of low prevalence, administer the Tuberculosis (TB) Questionnaire annually beginning at 1 year of age. In areas of high prevalence, administer the TB skin test at 1 year of age, once between 4 through 6 years of age, and once between 11 through 17 years of age. Administer the TB Questionnaire annually beginning at 2 years of age and thereafter at checkups. All clients should return for the provider to read the skin test. The TB Questionnaire is available in the Texas Medicaid Provider Procedures Manual (TMPPM).
5. All blood specimens with the exception of specimens related to hyperlipidemia, type 2 diabetes, HIV, and syphilis (RPR) screening, are to be submitted to the DSHS Laboratory for analysis. Documented laboratory results obtained within the preceding month may be used to meet the laboratory testing requirement and must include the date(s) of service, clear reference to the previous visit by the same provider, or results obtained from another provider.
6. Newborn screening (hereditary/metabolic testing for disorders recommended by the American College of Medical Genetics [ACMG]) is required by Texas law before hospital discharge and again between 1 and 2 weeks of age. Date and results of the second newborn screening are to be documented. The results of the questions contained in the Lead Exposure Questionnaire (available in the TMPPM) if documented client's record is acceptable at other visits.
7. Anemia screening is required. If immediate results are needed, the specimen may be processed in the office/clinic. The results must be documented in the client's medical record. Hemoglobin (Hgb) and hematocrit (Hct) testing conducted at a Women, Infants, and Children (WIC) clinic or in a provider's office are acceptable within 30 days if date and value are documented.
8. A blood lead level is mandatory at 12 and 24 months of age or any first checkup after 12 or 24 months of age, if there are no documented blood lead level results available. The results of the questions contained in the Lead Exposure Questionnaire (available in the TMPPM) if documented client's record is acceptable at other visits.
9. Hgb type is part of the newborn screening and should not be repeated if previously performed and results are documented in the client's chart.
10. Sexually transmitted diseases (STD) (including but not limited to evaluation for genital warts, cultures for gonorrhea and Chlamydia, and blood test for syphilis) and Human immunodeficiency virus (HIV) (actual testing is voluntary)
11. Cervical cancer screening for adolescent females:
   - Three years after the initiation of sexual activity
12. Vaccines must be obtained from the Texas Vaccines for Children Program at DSHS and administered at the time of the checkup, unless medically contraindicated or because of parent's reasons of conscience including a religious belief. Clients must not be referred to the local health department for immunizations.
13. The provider must refer all clients to a dental home for dental checkups beginning at 6 months of age and every 6 months thereafter. Patients are eligible for emergency dental treatment at any time. Parents may self-refer for dental care at any age, including younger than 6 months.
14. Anticipatory guidance includes health education and counseling, is a required integral part of each checkup, and must be face-to-face with the child's parent/caretaker and face-to-face with adolescents.

Note: Additional information is available in the TMPPM. To quickly reference the subjects listed above, refer to the manual's Index or use the Search tool available in the electronic edition.
6.3.2 Screening Components With Additional Requirements

6.3.2.1 Developmental Screening

Developmental screening is a required component of every checkup for clients who are birth through 6 years of age.

As a THSteps medical service, developmental screenings (procedure code 96110) or autism screenings (procedure code 96110 with modifier U6) is limited to once per day per client by the same provider or provider group and will be denied unless submitted by the same provider or provider group for the same date of service as a checkup, exception-to-periodicity checkup, or follow-up visit.

For clients who are 9 months through 4 years of age, the medical checkups must include a standardized developmental screen. Providers must use a standardized tool when performing a developmental or autism screening. A standardized screen is not required at other checkups up to and including the 6-year checkup; however, developmental screening is required at these visits and includes a review of milestones (gross and fine motor skills, communication skills, speech-language development, self-help/care skills, and social, emotional, and cognitive development) and mental health and is not considered a separate service.

Providers may be reimbursed for the recommended screening tools listed in the table below in addition to the checkup visit at specific age visits. THSteps accepts the following recommended standardized tools at the following ages:

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<th>Screening Ages</th>
<th>Developmental Screening Tools</th>
<th>Autism Screening Tools</th>
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<td>9 months</td>
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<td>1 year</td>
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<td>18 months</td>
<td>ASQ or PEDS</td>
<td>Modified Checklist for Autism for Toddlers (MCHAT)</td>
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<td>24 months</td>
<td>ASQ or PEDS</td>
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<td>30 months</td>
<td>ASQ or PEDS (if not completed at 24 months or with provider/parental concern)</td>
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<td>4 years</td>
<td>ASQ, ASQ-SE, or PEDS</td>
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Through August 31, 2011, providers may choose to use a standardized screening tool that is not listed in the Required Screening Ages and Recommended Tools table to complete the requirements of a medical checkup visit; however, providers may not submit a claim for a tool that is not listed in the table. If a standardized screen that is not listed is billed, it will be subject to recoupment.

Autism screening is required at 18 months of age.

If a developmental or autism screening that is required in the Required Screening Ages and Recommended Tools table is not completed during a checkup, the provider must document the reason why the screening was unable to be completed and schedule a follow-up appointment to complete the screening as soon as possible.

The provider must also complete a standardized screening when seeing a client who is 6 months through 6 years of age for the first time at any checkup.
If a provider administers a standardized developmental screening at additional checkups other than those listed in the Required Screening Ages and Recommended Tools table, the provider must document the rationale for the additional screening, which may be due to provider or parental concerns. Developmental screening that is completed without the use of one of the recommended standardized screening tools is not a separately payable benefit.

Clients who are birth through 35 months of age with suspected developmental delay must be referred to ECI within 2 working days of identification even if referred to an appropriate provider for further testing. If the client is 3 years of age or older, referral should be made to the local school district special education program.

Standardized developmental screening may be performed outside a THSteps medical checkup as part of development and neurological assessment and testing.

Refer to: Subsection 6.3.19, “Developmental and Neurological Assessment and Testing” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2 Provider Handbooks) for information related to developmental screening.

Administration of the Mini Mental State Examination (MMSE) is considered part of an E/M service and is not separately reimbursed.

6.3.2.2 Referrals for Developmental Assessment

Referral for an in-depth developmental evaluation is determined by the criteria of the specific tool, which the screener should understand. Referral for in-depth evaluation of development should be provided when parents express concern about their client’s development, regardless of scoring on a standardized development screening tool.

An ECI program serves clients who are birth through 35 months of age with disabilities or developmental delays. Under federal and state regulations, all healthcare professionals are required to refer children to the Texas ECI program within 2 business days of identifying a disability or a suspected delay in development. If the client is 3 years of age or older, referral should be made to the local school district’s special education program. Referrals may be based on professional judgment or a family’s concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

Refer to: Appendix 4, “Texas Health Steps Statutory State Requirements” of this handbook for more information.

6.3.2.3 Mental Health

Whenever a mental health crisis is suspected, every effort must be made to secure a prompt mental health evaluation and any medically necessary treatment for the client.

An emergency mental health referral for evaluation and/or treatment must always be made when any of the following are identified during a mental health screening:

- Suicidal thoughts, threats, or behaviors
- Homicidal thoughts, threats, or behaviors

When the clinician conducting the mental health screen has the appropriate training and credentials to conduct the mental health evaluation and provide the mental health treatment (mental or behavioral health problems, mental illnesses, or substance abuse or dependence), the clinician may choose to provide the mental health services or refer the client to an appropriate clinician. Clinicians who do not have these qualifications must refer clients to a qualified mental health specialists for such care.

For additional information about conducting a mental health screen, providers can refer to the THSteps online educational module “Mental Health Screening” at www.txhealthsteps.com.
6.3.2.4 Sensory Screenings

Vision and hearing screening are not covered when completed to meet day care, Head Start, or school program requirements unless completed during an acute care visit in a clinic setting. Clients with abnormal screening results must be referred to an optometrist or ophthalmologist experienced with the pediatric population. Clients who are at high risk for vision conditions must be referred to an ophthalmologist experienced with the pediatric population.

Documentation of test results from a school vision or hearing screening program may replace the required objective screening if the test is conducted within 12 months of the checkup.

6.3.2.4.1 Vision Screening

Vision screening is a required component of a THSteps medical checkup for clients from birth through 20 years of age. Vision screening may also be completed at any medical checkup or office visit upon request of a parent or referral from a school vision screening program or school nurse.

Clients Who Are Birth Through 2 Years of Age
All clients must be screened for vision problems by history, observation, and physical exam and referred to an ophthalmologist if at high risk for eye problems.

Clients Who Are 3 Through 20 Years of Age—Objective Screening
All clients 3, 4, 5, 6, 8, 10, 12, 15, and 18 years of age must be screened for vision acuity using an age-appropriate standardized vision chart. Standardized vision acuity must also be performed upon parental request.

Clients Who Are 3 Through 20 Years of Age—Subjective Screening
A vision acuity screen is not required for other ages listed on the THSteps Periodicity Schedule; however, subjective screening for vision problems is required at all other checkups and includes client history, physical assessment, and observation of the client for signs of vision difficulty.

- Clients with abnormal screening results must be referred to an optometrist or ophthalmologist experienced with the pediatric population.
- Clients who are at high risk for eye abnormality must be referred to an ophthalmologist experienced with the pediatric population.

Refer to: Section 3, “Vision Care Professionals” in Vision and Hearing Services Handbook (Vol. 2, Provider Handbooks) for additional vision services.

6.3.2.4.2 Hearing Screening

Hearing screening must be completed during each THSteps medical checkup. Clients with abnormal screening results must be referred to an appropriate provider. Audiometric screening procedure codes 92551 and 92552 are denied if billed on the same day by the same provider as a medical checkup.

Inpatient Hearing Screening — Newborn Hearing Screening

Health Safety Code, Chapter 47, Vernon’s Texas Codes Annotated mandates that a hearing screening must be offered at the birthing facility before hospital discharge. The hospital is responsible for the purchase of equipment, training of personnel, screening of the newborns, certification of the program in accordance with DSHS standards, and notification to the provider, parents, and DSHS of screening results. There is no additional Medicaid reimbursement for the hearing screening, as the procedure is part of the newborn diagnosis-related group (DRG). Hospitals should use the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) procedure code 09547 to report this newborn hearing screen on the UB-04 CMS-1450 claim form.

This facility-based screening also meets the physician’s required component for hearing screening in the inpatient newborn THSteps medical checkup. The physician must assure that the hearing screening is offered or completed before discharging the newborn unless the birthing facility is exempt under the law...
from performing hearing screenings. In that case, the physician must assure there is an appropriate referral for a hearing screening to a birthing facility participating in the Newborn Hearing Screening Program.

The physician should discuss the screening results with the parents, especially if the hearing screening results are abnormal, and should order an appropriate referral for further diagnostic testing. If the results are abnormal, parent/legal guardian consent must be obtained to send information to DSHS for tracking and follow-up purposes.

**Clients Who Are Birth Through 3 Years of Age**

THSteps hearing screening for this age group consists of all of the following:

- Observation and history recording obtained from a responsible adult familiar with the client
- Completion of the Hearing Checklist for Parents form
- Referral of high-risk clients to a physician who renders audiology services

*Note: Clients who are birth through 35 months of age and who have a suspected hearing loss must be referred to ECI within two business days of being identified, even if they are referred to an appropriate provider for further testing.*

**Clients Who Are 4 Through 20 Years of Age — Objective Screening**

All clients 4, 5, 6, 8, and 10 years of age must be screened for hearing loss with pure tone audiometric threshold screening. Pure tone audiometric threshold screening must also be performed upon parental request.

**Clients Who Are 4 Through 20 Years of Age — Subjective Screening**

A standardized screen is not required for other ages listed on the THSteps Periodicity Schedule; however, subjective hearing screening is required at these visits and includes client history and observation of the client for the ability to answer questions and follow directions. Clients with abnormal screening results must be referred to an appropriate provider.

*Refer to:* Section 2, “Hearing Aid Professionals” in Vision and Hearing Services Handbook (Vol. 2, Provider Handbooks) for newborn hearing screening requirements and additional hearing services.

### 6.3.2.5 Tuberculosis Screening

In areas of low TB prevalence, administer the Tuberculosis (TB) Screening and Education Tool annually beginning at 1 year of age. In areas of high prevalence, administer the TB skin test at 1 year of age, once between 4 years of age through 6 years of age, and one between 11 years of age through 17 years of age. Administer the TB Questionnaire annually beginning at 2 years of age and thereafter at other medical checkups.

Providers should contact their local or regional health department to determine whether their service area is a low- or high-prevalence area for TB. A listing of counties with a high prevalence of TB is available at www.dshs.state.tx.us/idcu/disease/tb/statistics/hiprev/default.asp.

Providers can also call the TB program at 1-512-458-7447 for more information.

A follow-up visit (procedure code 99211) is required to read all TB skin tests. The provider may bill the follow-up visit with a provider identifier and THSteps benefit code.

If further evaluation is required to diagnose either latent TB infection or active TB disease, the provider may bill the appropriate office visit code. Diagnosis and treatment are provided as a medical office visit.


Form CH.26, “PPD Agreement for Texas Health Steps Providers” in Appendix A, THSteps Forms, in this handbook.

6.3.2.6 Laboratory Procedures

The complete medical checkup includes specimen collection, supplies, mailing and shipping supplies, and receiving test results from the DSHS Laboratory. These services and supplies are limited to THSteps medical checkup laboratory services provided in the course of a medical checkup to THSteps clients. Unauthorized use of services and supplies is a violation of federal regulations.

Note: For newborn screening, only the specimen collection form (NBS-3), mailing envelope and provider address labels are provided. Lancets, mailing, and shipping costs are the responsibility of the submitter.

6.3.2.6.1 Laboratory Services

Age-appropriate laboratory testing, as noted on the THSteps Medical Checkup Periodicity Schedule (including the footnotes), is considered part of the THSteps medical checkup.

DSHS makes laboratory services available free to all enrolled THSteps medical providers for THSteps medical checkups only. THSteps laboratory services provided by a private laboratory and a medical provider are not reimbursed.

Example: If a provider needs immediate results for the anemia screening, the specimen may be processed in the office/clinic, and the test results must be documented in the client’s medical record but will not be reimbursed.

Exception: Specimens related to screening for Type 2 diabetes, hyperlipidemia, HIV, and syphilis may be sent to the laboratory of the provider’s choice for processing and analysis, including those obtained for managed care clients.

Documented laboratory test results obtained within the preceding month may be used to meet the laboratory testing requirement and must include:

- The dates of service (DOS).
- Clear reference to the previous visit by the same provider or results obtained from another provider.

The date of service for the laboratory testing is to be the date the specimen was obtained as part of the medical checkup, follow-up visit, or exception-to-periodicity visit.

The procedure codes for any laboratory testing services other than screening for Type 2 diabetes, hyperlipidemia, HIV, and syphilis are informational when obtained on the same day a checkup is completed, even if an acute care visit is performed on the same date of service.

If the laboratory testing as identified on the THSteps Medical Checkup Periodicity Schedule (including the footnotes) is obtained as part of an E/M visit on a different date of service than a checkup, the services may be considered as separate services and may be sent to the laboratory of the provider’s choice.

Laboratory specimens obtained for diagnostic evaluation, rather than for screening purposes and performed on the same day as a checkup, may be considered as separate services unless the test is required as part of a checkup. If the test is required as part of the checkup, the laboratory specimens, with the exception of screening tests for hyperlipidemia, Type 2 diabetes, HIV and syphilis, must be submitted to the DSHS Laboratory for testing. Diagnostic specimens that are not part of the checkup can be sent to the laboratory of the provider’s choice.
Providers may receive reimbursement for the complete medical checkup. The complete medical checkup includes the DSHS Laboratory providing specimen collection supplies, mailing, and shipping supplies, and receiving test results from the DSHS Laboratory for specimens submitted to the DSHS Laboratory for testing. These services and supplies are limited to THSteps medical checkup laboratory services provided in the course of a medical checkup to THSteps clients. Unauthorized use of services and supplies is a violation of federal regulations.

**Note:** For newborn screening, only the specimen collection form (NBS 3), mailing envelope and provider address labels are provided. Lancets and mailing/shipping costs are the responsibility of the submitter.

Laboratory services that are related to a THSteps medical checkup are available from the DSHS Laboratory and may not be billed separately with an office visit or consultation on the same day as a THSteps medical checkup.

Providers can refer to the laboratory test procedure codes table below for tests listed on the THSteps Periodicity Schedule that are available from the DSHS Laboratory.

The following procedure codes may not be billed separately with an office visit or consultation on the same day as a THSteps medical checkup either by a provider or laboratory. Claims for procedure codes listed below submitted by a provider or a commercial laboratory for the same DOS as a THSteps medical checkup are denied and are subject to retrospective review:

<table>
<thead>
<tr>
<th>Laboratory Test Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>83020</td>
</tr>
<tr>
<td>88142</td>
</tr>
<tr>
<td>88166</td>
</tr>
</tbody>
</table>

The following procedure codes are related to laboratory testing for hyperlipidemia, Type 2 diabetes, HIV, and syphilis that may be sent to the DSHS Laboratory or to a laboratory of the provider's choice. Laboratories that bill for these procedure codes on the same date of service as a medical checkup visit may be reimbursed separately. Providers who obtain and process these specimens in-house are not reimbursed separately.

<table>
<thead>
<tr>
<th>Laboratory Test Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>80061</td>
</tr>
</tbody>
</table>

**6.3.2.6.2 Laboratory Supplies**

The DSHS Laboratory verifies enrollment of THSteps medical providers before sending laboratory supplies and informational packet to the medical providers. Newly enrolled providers should contact the DSHS Laboratory to request laboratory supplies. Upon request, the DSHS Laboratory provides THSteps medical providers with laboratory supplies associated with specimen collection, submission, and mailing and shipping of required laboratory tests related to medical checkups. Requests for specimen requisition forms are routed to the DSHS Laboratory reporting staff and mailed separately to the providers. The Child Health Laboratory Supplies Order Form lists the laboratory supplies that the DSHS Laboratory provides to THSteps medical providers.

To obtain a THSteps (Child Health Laboratory Supplies Order Form), providers can call 1-512-458-7661 or 1-888-963-7111, ext. 7661, or download the form online at www.dshs.state.tx.us/lab/MRS_forms.shtm.
6.3.2.6.3 Newborn Screening Supplies

Providers that perform newborn screening (NBS) can order supplies by submitting a Newborn Screening Supplies Order Form to the DSHS Laboratory. The Newborn Screening Supplies Order Form lists the NBS supplies that the DSHS Laboratory provides to medical providers.

To obtain a Newborn Screening Supplies Order Form, medical providers can call 1-512-458-7661 or 1-888-963-7111, ext. 7661, or download the form online at www.dshs.state.tx.us/lab/MRS_forms.shtm.

Contact information for requesting laboratory supplies:

Container Preparation
Laboratory Services Section, MC 1947
Department of State Health Services
PO Box 149347
Austin, TX 78714-93471
1-512-458-7661 or 1-888-963-7111, Ext. 7661
Fax: 1-512-458-7672

6.3.2.6.4 Laboratory Submission

THSteps laboratory specimens submitted to the DSHS Laboratory must include on the DSHS Laboratory Request Form (Newborn Screening NBS 3, G-1B, G-2A, and/or G-2B as appropriate for test(s) requested) the client's name and Medicaid number as they appear on the Medicaid Identification (Form H3087). If a number is not currently available but is pending (i.e., a newborn or a newly certified client verified by a Medicaid Eligibility Verification [Form H1027] as eligible for Medicaid), providers must write "pending" in the Medicaid number space, which is located in the payor source section of the laboratory requisition form.

Laboratory specimens received at the DSHS Laboratory without a Medicaid number or the word "pending" written on the accompanying specimen submission form will be analyzed, and the provider will be billed.

Specimens submitted to the laboratory must also meet specific acceptance criteria. For additional information on specimen submission, providers can refer to the DSHS Laboratory web page at: www.dshs.state.tx.us/lab/MRS_specimens.shtm

**Note:** If an extreme health problem exists and telephone results are needed quickly, providers should make a request on the laboratory form. With the exception of weekends and holidays, routine specimens are analyzed and reported within 3 business days after receipt by the DSHS Laboratory. Critical abnormal test results (e.g., hemoglobin equal to or below 7g/dL or blood lead level greater than or equal to 40 mcg/dL) are identified in the laboratory within 36 hours after receipt of specimens and are reported to the submitter by telephone within 1 hour of confirmation.

The THSteps laboratory specimens that can be mailed at ambient temperature can be sent to the DSHS Laboratory Services Section through the U.S. Postal Service at no cost using the provided business reply labels:

DSHS Laboratory Services Section
Walter Douglass
PO Box 149163
Austin, TX 78714-9803
1-512-458-7318 or 1-888-963-7111 Ext. 7318
Fax: 1-512-458-7294
THSteps laboratory specimens that require overnight shipping on cold packs through a courier service must be sent to the DSHS Laboratory Services Section at:

DSHS Laboratory Services Section, MC-1947
1100 West 49th Street
Austin, TX 78756-3199

Newborn Screening specimens can be sent through the U.S. Postal Service to:

Texas Department of State Health Services
Laboratory Services Section
P.O. Box 149341
Austin, Texas 78714-9341

6.3.2.6.5 Send Comments

Providers with comments or feedback about THSteps specimen collection supplies should contact the DSHS Laboratory. Supplies are evaluated continually, and feedback from supply users is useful. Documented comments may support, justify, or initiate a change in a provided item. Providers can send a brief letter or fax to the following address:

Quality Assurance Unit
Laboratory Services Section, MC 1947
Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-512-458-7672

6.3.2.6.6 Required Laboratory Tests Related to Medical Checkups

The following laboratory screening procedures are required components of the THSteps medical checkup and are to be performed in accordance with the age and frequency specified on the THSteps medical checkup periodicity schedule. Due to changes in specimen collection, handling, and submission criteria, providers should contact the DSHS Laboratory for the most current specimen requirements by calling 1-888-963-7111, Ext. 7430 or visiting the DSHS website at www.dshs.state.tx.us/lab/MRS_labtests_toc.shtml.

**Hemoglobin or Hematocrit**

Hemoglobin or hematocrit levels are required. These tests may be completed in a provider’s office if there is an urgent need for test results and test results must be documented in the client’s medical record.

**Lead Screening and Testing**

In accordance with current federal regulations, THSteps requires that clients be screened for lead poisoning through either blood tests and/or parent questionnaires at 6, 9, 12, 15, 18, 24, and 30 months of age and annually until 6 years of age.

Lead poison screening is required from 6 months through 6 years of age. A blood lead level is mandatory at 12 and 24 months of age or any first checkup after 12 or 24 months of age, if there is no documented blood lead level results available. The results of the questions contained in the Lead Exposure Questionnaire, if documented in the client’s record, is acceptable at other visits.

Providers may download the Pb-110: Risk Assessment for Lead Exposure Questionnaire, which is provided in both English and Spanish at www.dshs.state.tx.us/lead.

Providers may obtain more information about the medical and environmental management of lead poisoned children from the DSHS Childhood Lead Poisoning Prevention Program by calling 1-800-588-1248 or visit the web page at www.dshs.state.tx.us/lead

Refer to: Appendix 4, “Lead Screening” in this handbook for more information on lead screening procedures and follow-up
Hemoglobin Type/Hemoglobin Electrophoresis
If the hemoglobin type has been done as a part of newborn screening and results are documented on the chart, the test does not need to be repeated. Results from dates of service on or after July 12, 2002, are available from the DSHS Laboratory. The test also may be performed at the provider’s discretion, as appropriate for age and population groups.

Hyperlipidemia
Screening for hyperlipidemia is based on risk assessment. THSteps does not provide a formal risk assessment tool. Providers may refer to the AAP policy statement on cholesterol screening for more information. Specimens may be sent to the laboratory of the provider’s choice, including the DSHS Laboratory.

Diabetes
Screening for risk of Type 2 diabetes is based on risk assessment. THSteps does not provide a formal risk assessment tool. Specimens may be sent to the laboratory of the provider’s choice, including the DSHS Laboratory.

Newborn Screening
The mandated newborn screen at 1 to 2 weeks of age is a required component of the THSteps medical checkup. Clients should not be referred to the local health department or other providers for this service.

Health and Safety Code, Chapter 33, Vernon’s Texas Codes Annotated, requires testing for the disorders recommended by the American College of Medical Genetics (ACMG) on all newborns. This testing is the responsibility of any provider attending the newborn. All newborns must be tested at 24-48 hours of age and a second time at 1 to 2 weeks of age. If there is any doubt that a client younger than 12 months of age was properly tested, the provider should submit the blood sample on the appropriate DSHS Form NBS 3 to the DSHS Newborn Screening Laboratory.

Note: The results are mailed to the address that the provider indicated on Form NBS 3. Recommendations for necessary follow-up procedures are included with the report. The DSHS NBS Case Management staff will contact providers when there are significant abnormalities.

The newborn screening should only be obtained prior to 1 week of age if a first newborn screen was not obtained before discharge from the hospital. The second newborn screening should be completed at the 1- or 2-week visit. If a potential or confirmed medical problem related to the newborn screen results requires monitoring, it is recommended that the infant be seen in a clinic or medical provider’s office, and Texas Medicaid should be billed using codes for an acute care visit.

6.3.2.6.7 Additional Required Laboratory Tests Related to Medical Checkups for Adolescents
The following is a list of required laboratory tests related to medical checkups for adolescents and guidelines for testing for sexually transmitted diseases (STDs).

Communicable Disease Reporting
Diagnoses of sexually transmitted diseases (STDs), including HIV, are reportable conditions under 25 TAC, Chapter 97. Providers must report confirmed diagnoses of STDs as required by 25 TAC §97.132.

Testing for Sexually Transmitted Diseases (STDs)
Syphilis Testing
Syphilis testing should be performed on adolescents that are at high risk for infection. Specimens may be sent to the laboratory of the provider’s choice, including the DSHS Laboratory.

Gonorrhea and Chlamydia Infection Testing
Testing for gonorrhea and chlamydia should be performed on adolescents that are at high risk for infection.
**HIV Testing**

It is critical to maintain confidentiality when caring for clients, as well as their specimens. Testing should be performed only after informed consent is obtained from the adolescent. Informed consent does not have to be written as long as there is documentation in the medical record that the test has been explained and consent has been obtained. Specimens may be sent to the laboratory of the provider’s choice, including the DSHS Laboratory.

HIV testing may be performed for adolescents without requirement of parental consent. Adolescents at risk for HIV infection should be offered confidential HIV screening. If the client refuses the HIV test, the provider may not perform the test and must explain the option of anonymous testing and refer the client to a testing facility that offers anonymous testing. A notation must be made in the medical record that notification of the HIV test and the right to refuse was given. Providers may call the HIV/STD InfoLine for referrals to HIV/AIDS testing sites; prevention, case management, and treatment providers; STD clinics; and other related service organizations. The HIV/STD InfoLine is 1-800-299-2437. This toll-free HIV/Acquired Immunodeficiency Syndrome (AIDS) and STD information and referral service is available for English- and Spanish-speaking callers and for those who are hearing-impaired.

**Cervical Cancer Screening**

The first Pap smear should be obtained at 21 years of age, 3 years from the onset of sexual activity, or at any other age based on provider discretion.

**Mailing Specimens and Ordering Supplies for PAP Screen Testing**

THSteps providers can call for information, mail specimens to, or order supplies for obtaining Pap smears for THSteps adolescent screening from the following laboratory:

Women’s Health Laboratories  
2303 SE Military Drive, Suite 1  
San Antonio, TX 78223  
Customer Service: 1-888-440-5002 or 1-210-531-4596  
Fax: 1-210-531-4506  
www.dhs.state.tx.us/lab/whl.shtm

To order supplies, providers should do the following:

- Use order Form AG-30, 1643, or letterhead stationery.
- Fax the supply order form or include in the specimen packaging.
- Request supplies by telephone or email.
- Include their THSteps provider identifier.

The following supplies are available for order:

<table>
<thead>
<tr>
<th>Conventional Pap Smears</th>
<th>Surepath Liquid-Based Pap Smears</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pap kits</td>
<td>Cervex brush</td>
</tr>
<tr>
<td>M-47 forms</td>
<td>Cytorich preservative vial</td>
</tr>
<tr>
<td>Cardboard boxes</td>
<td>M-47 form</td>
</tr>
<tr>
<td>Labels</td>
<td>Zip-lock biohazard transport bag</td>
</tr>
<tr>
<td>WHL supply order form</td>
<td>WHL supply order form</td>
</tr>
</tbody>
</table>

Providers that are already on the automated system through the DSHS Pharmacy are encouraged to continue using this system. Larger numbers of supplies are sent through the DSHS Pharmacy. Providers with consistent monthly workload volumes can request to be set up with a standard monthly order that is shipped at the same time each month.
6.3.2.6.8 Laboratory Reporting

A computer-generated result report is mailed or faxed to the submitting THSteps medical checkup provider. A statistical report is mailed quarterly to providers documenting their total number of submissions by diagnosis and adequacy. The DSHS Laboratory has web-based services (remote order and result reporting) available for THSteps and Newborn Screening laboratory services. For more information, providers can visit the DSHS website at www.dshs.state.tx.us/lab/remoteData.shtml or call 1-888-963-7111, Ext. 6030.

6.3.2.7 Administrations and Immunizations

Providers must screen the immunization status at every medical checkup. The necessary vaccines and toxoids must be administered at the time of the checkup unless medically contraindicated or because of parent’s reasons of conscience including religious beliefs.

Vaccines and toxoids must be administered according to the current ACIP "Recommended Childhood and Adolescent Immunization Schedule - United States."

Providers must not refer clients to the local health department or other entity for immunization administration. Vaccines/toxoids must be obtained from TVFC for clients who are birth through 18 years of age.

The specific diagnosis necessitating the vaccine/toxoid is required when billing with the following administration procedure codes in combination with an appropriate vaccine/toxoid procedure code. Diagnosis procedure code V202 may be used unless a more specific diagnosis code is appropriate:

<table>
<thead>
<tr>
<th>Administration Procedure Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>90465</td>
<td>90466</td>
</tr>
</tbody>
</table>

Immunization administration fees are reimbursed based on the number of state-defined components administered per injection and may or may not require the use of one of the following modifiers. Combined antigen vaccines (e.g., DTaP or MMR) are considered as one dose.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U2</td>
<td>State-defined modifier: Administration of vaccine/toxoid with two state-defined components</td>
</tr>
<tr>
<td>U3</td>
<td>State-defined modifier: Administration of vaccine/toxoid with three state-defined components</td>
</tr>
</tbody>
</table>

The following vaccines are defined as having one state-defined component and the administrative procedure code do not require a modifier:

<table>
<thead>
<tr>
<th>Vaccine Procedure Codes With One State-Defined Component</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>90632*</td>
<td>90633*</td>
</tr>
<tr>
<td>90658*</td>
<td>90660*</td>
</tr>
<tr>
<td>90706</td>
<td>90707*</td>
</tr>
<tr>
<td>90743</td>
<td>90744*</td>
</tr>
</tbody>
</table>

* TVFC-distributed vaccine/toxoid

**Note:** Vaccines that are not are not identified as being distributed through TVFC are not reimbursed separately.
The following vaccines are defined as having two state-defined components and the administrative procedure code must be billed with the state-defined modifier U2.

**Vaccine Procedure Codes With Two State-Defined Components**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90636</td>
<td></td>
</tr>
<tr>
<td>90696</td>
<td></td>
</tr>
<tr>
<td>90710*</td>
<td></td>
</tr>
<tr>
<td>90715*</td>
<td></td>
</tr>
<tr>
<td>90721</td>
<td></td>
</tr>
<tr>
<td>90748*</td>
<td></td>
</tr>
</tbody>
</table>

* TVFC-distributed vaccine/toxoid

**Note:** Vaccines that are not are not identified as being distributed through TVFC are not reimbursed separately.

The following vaccines are defined as having three state-defined components and the administrative procedure code must be billed with the state-defined modifier U3.

**Vaccine Procedure Code With Three State-Defined Components**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90698*</td>
<td></td>
</tr>
<tr>
<td>90723*</td>
<td></td>
</tr>
</tbody>
</table>

* TVFC-distributed vaccine/toxoid

Providers may use the state-defined modifier U1 in addition to the associated administered vaccine procedure code for clients birth through 18 years of age and the vaccine was unavailable through TVFC.

**Modifier | Description**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>State-defined modifier: Vaccine(s)/toxoid(s) privately purchased by provider when TVFC vaccine/toxoid is unavailable</td>
</tr>
</tbody>
</table>

**Note:** "Unavailable" is defined as a new vaccine approved by the Advisory Committee on Immunization Practices (ACIP) that has not been negotiated or added to a TVFC contract, funding for new vaccine that has not been established by TVFC, or national supply or distribution issues.

Modifier U1 may not be used for failure to enroll in TVFC, maintain sufficient TVFC vaccine/toxoid inventory or clients who are 19 years of age through 20 years of age.

For all immunizations, if only one immunization is administered during a checkup or visit, providers should bill the appropriate administration procedure code with a quantity of 1 in addition to the appropriate immunization procedure code administered.

If 2 or more immunizations are administered, providers should bill the appropriate administration procedure codes 90465, 90467, 90471, or 90473 with a quantity of 1, procedure codes 90466, 90468, 90472, and/or 90474 with a quantity of 1 or more (depending on the number of vaccines administered), and the procedure codes that describe each immunization administered.

When a vaccine given has more than one state-defined component, the provider should bill the corresponding administration code with the appropriate modifier. Providers should separate administration codes with different modifiers on different details lines. Provider can bill on one-detail line administration codes with no modifier or the same modifier.

**Example:** Provider billing for vaccine procedure codes 90648, 90723, 90680, and 90649. Provider should bill administrative code 90471 with modifier U3 to identify the vaccine with 3 state-defined components (90723), 90472 with a quantity of 2 for the administration of 90648 and 90649 and oral administration code 90473 for vaccine 90680.

6.3.2.7.1 Vaccine Information Statement (VIS)

A VIS is required by federal mandate to inform parents and vaccine recipients of the risks and benefits of the vaccine they are about to receive. Not only is it important to explain the risks and benefits before a vaccine is administered, it is also important that providers use the most current forms available. For
more about immunizations, vaccine-preventable diseases, or literature and forms, providers can call the DSHS Immunization Branch at 1-800-252-9152 or review information at www.dshs.state.tx.us/immunization/default.shtm.

Refer to: Appendix B, “Immunizations” in this handbook.
Form CH.29, “TVFC Provider Enrollment (3 Pages)” in Appendix A, “THSteps Forms,” of this handbook for more information on enrolling as a TVFC provider.
Subsection B.2, “Recommended Childhood Immunization Schedule” in Appendix B, “Immunizations,” of this handbook.
The THSteps online education module "Immunizations," which is located on the THSteps website at www.txhealthsteps.com, for more information about immunizations.

6.3.2.8 Dental Screening and Intermediate Oral Evaluation with Fluoride Varnish Application in the Medical Home

Based on the American Academy of Pediatric Dentistry’s (AAPD) definition of a dental home, Texas Medicaid defines a dental home as the dental provider who supports an ongoing relationship with the client that is inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. In Texas, establishment of a client’s dental home should begin at 6 months of age but no later than 12 months of age and includes referral to dental specialists when appropriate.

The physician must refer clients to a dental home for dental checkups beginning at 6 months of age and at each medical checkup thereafter. A parent/guardian of the client may self-refer for dental services at any age, including younger than 12 months of age, and may choose any THSteps dental provider.

6.3.2.8.1 Dental Screening
Dental screening is a part of the medical checkup physical examination and must include:

- Inspection of teeth for signs of early childhood caries.
- Inspection of the oral soft tissues for any abnormalities.
- Anticipatory guidance to include:
  - The need for thorough daily oral hygiene practices.
  - Potential gingival manifestations for clients with diabetes and clients under long-term medications therapy.
  - Information that THSteps eligibility qualifies the client for dental services.

6.3.2.8.2 Intermediate Oral Evaluation with Fluoride Varnish Application
An intermediate oral evaluation with fluoride varnish application (procedure code 99429) is a benefit for clients 6 months of age through 35 months of age.

The intermediate oral evaluation with fluoride varnish application must be billed on the same date of service as a medical checkup visit and is limited to 6 services per lifetime by any provider. Procedure code 99429 must be billed with modifier U5 and diagnosis code V202.

An intermediate oral evaluation with fluoride varnish application is limited to THSteps medical checkup providers who have completed the required benefit education and are certified by DSHS Oral Health Program to perform an intermediate oral evaluation with application of fluoride varnish. The intermediate oral evaluation with fluoride varnish application add-on includes the following components:

- Intermediate oral evaluation
- Fluoride varnish application
• Dental anticipatory guidance to include:
  • The need for thorough daily oral hygiene practices
  • Education in potential gingival manifestations for clients with diabetes and clients under long-term medication therapy
  • THSteps eligibility qualifies the client for dental services
  • Diet, nutrition and food choices
  • Fluoride needs
  • Injury prevention
  • Antimicrobials, medications, and oral health

If the client has no erupted teeth, additional dental anticipatory guidance is expected.

  *Note: The physician must complete the intermediate oral evaluation but can delegate all other components.*

6.3.2.9 Anticipatory Guidance
Anticipatory guidance is a federally mandated component of the THSteps medical checkup and includes health education and counseling. Face-to-face health education and counseling with parents or guardians and clients are required to assist parents in understanding what to expect in terms of the client’s development and to provide information about the benefits of healthy lifestyles and practices, and accident and disease prevention. Written material also may be given but does not replace face-to-face counseling.

6.4 Documentation Requirements
All THSteps services require documentation to support the medical necessity of the services rendered including THSteps medical services. THSteps services are subject to retrospective review and recoupment if documentation does not support the services billed.

6.4.1 THSteps Medical Checkups—Documentation of Completed Checkups
To assure completion of comprehensive medical checkups and the quality of care provided, providers must document all components of the THSteps medical checkups as they are completed. Clinical charts are subject to quality review activities including random chart review and focused studies of well-child care.

The required components of the medical checkup must be documented in the client’s medical records. If the component cannot be completed due to extenuating circumstances, such as the client’s illness or lack of cooperation or the parent’s refusal to give consent for a specific component, the provider must document in the client’s medical record why the component was not completed and must schedule a follow-up visit as appropriate. A checkup is considered complete if the provider has attempted to complete all required components and documentation supports the reason why the required component could not be completed.

Documentation for a follow-up visit must include:
  • Reason for the visit(s)
  • Component(s) completed

Documentation of the questions contained in the following screening tools are required for THSteps risk identification:
  • Hearing Checklist for Parents
  • Tuberculosis (TB) Screening and Education Tool
• Form Pb-110, Risk Assessment for Lead Exposure

Documentation of these screening tools must be included in the client’s medical record as follows:

• If another program requires the screening tool to be submitted, it must be completed and included in the client’s medical record.

• If another program does not require the screening tool to be submitted, it must have one of the following forms of documentation included in the client’s medical record:
  • The completed screening tool(s) with results
  • The completed questions to the tool(s) within a provider-created medical record
  • The results of the completed screening tool(s)

• Providers may be asked to provide the screening tool used to complete the screening.

All other THSteps forms are optional.

Any component of the checkup obtained within the preceding month may be used to meet the checkup requirement and must include:

• The date(s) of service

• Clear reference to the previous visit by the same provider or results obtained from another provider

In addition to the required documentation for a checkup, the client’s medical record must include the reason for the exception-to-periodicity checkup.

6.4.1.0.1 Separate Identifiable Acute Care Evaluation and Management Visit

If an acute or chronic condition that requires E/M beyond the required components for a medical checkup is discovered, a separate E/M procedure code may be considered for reimbursement for the same date of service as a checkup or the client can be referred for further diagnosis and treatment.

• The client’s medical record must contain documentation that the separate identifiable service(s) were medically necessary and include a diagnosis other than V202 (routine infant or child health check) and treatment. Documentation must be made available to Texas Medicaid upon request.

• An insignificant or trivial problem/abnormality that is encountered in the process of performing a checkup and does not require additional work and performance of the key components of a problem-oriented E/M service cannot be considered a separate established patient E/M acute care visit.

6.5 Claims Filing and Reimbursement

Providers may refer to Volume 1 for general information regarding claims filing and reimbursement. See the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

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

Section 6, Claims Filing (Vol. 1, General Information) for general information about claims filing.


Section 2, Texas Medicaid Reimbursement (Vol. 1, General Information) for more information about reimbursement.

Subsection 2.2, “Reimbursement Methodology” in Section 2, Texas Medicaid Reimbursement (Vol. 1, General Information) for more information.

6.5.1 THSteps Medical Checkups

6.5.1.1 Claims Information

THSteps providers do not have to bill private insurance for a medical checkup; they can bill TMHP directly even if they know that the client has private insurance. For THSteps medical checkups, TMHP is responsible for determining whether a third-party resource (TPR) exists and for seeking payment from the TPR.

Providers should bill their usual and customary fee except for vaccines obtained from TVFC. Providers may not charge Medicaid or clients for the vaccine received from TVFC. Providers may charge a usual and customary fee not to exceed $14.85 for vaccine administration when providing immunizations to a client eligible for TVFC. Providers are reimbursed the lesser of the billed amount or the maximum allowable fee.

THSteps medical checkups may be billed electronically or on a CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. Providers may request information about electronic billing or the claim form by contacting the TMHP THSteps Contact Center at 1-800-757-5691.

All procedures, including the informational-only procedures, must have a billed amount associated with each procedure listed on the claim. Informational-only procedure codes must be billed in the amount of at least $.01.

Providers must record the following on the CMS-1500 claim form to receive reimbursement for a medical checkup:

- The provider identifier and benefit code
- The appropriate THSteps medical checkup procedure code (all ages) with diagnosis code V202
  - The condition indicator codes, which must be placed in 24C (ST, S2, or NU only)
  - The provider type modifiers
  - The exception-to-periodicity modifier, when applicable
- A TB skin test procedure code if a test was administered (1 through 20 years of age)
- The immunization administration and vaccine procedure codes if any were administered (all ages)
- The place of service must be 72 for RHCs
- The EP modifier must be used for FQHCs

6.5.1.2 Reimbursement

THSteps-enrolled providers are reimbursed for THSteps medical checkups and administration of immunizations in accordance with 1 TAC §355.8441.

THSteps medical checkups provided in an FQHC are reimbursed in accordance with 1 TAC §355.8261. RHCs are reimbursed using visit rates calculated in accordance with 1 TAC §355.8101.
# 7. CLAIMS RESOURCES

Refer to the following sections and/or forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acronym Dictionary</td>
<td>Appendix E (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Chemical Dependency Treatment Facility Claim Form example</td>
<td>Form CH.21, Section 9 of this handbook</td>
</tr>
<tr>
<td>CMS-1500 Claim Filing Instructions Claim Form Example</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Comprehensive Outpatient Rehabilitation Facility (CORF) (CCP Only) Claim Form Example</td>
<td>Form CH.22, Section 9 of this handbook</td>
</tr>
<tr>
<td>THSteps Dental Criteria for Dental Therapy Under General Anesthesia (2 Pages)</td>
<td>Form CH.15, Section 8 of this handbook</td>
</tr>
<tr>
<td>Donor Human Milk Request Form</td>
<td>Form CH.5, Section 8 of this handbook</td>
</tr>
<tr>
<td>Durable Medical Equipment (CCP Only) Claim Form Example</td>
<td>Form CH.24, Section 9 of this handbook</td>
</tr>
<tr>
<td>Case Management for Early Childhood Intervention (ECI) Claim Form Example</td>
<td>Form BH.5, Behavioral Health, Rehabilitation, and Targeted Case Management Services Handbook (Vol. 2, Provider Handbooks)</td>
</tr>
<tr>
<td>Medical Nutritional Counseling (CCP Only) Claim Form Example</td>
<td>Form CH.28, Section 9 of this handbook</td>
</tr>
<tr>
<td>Occupational Therapists (CCP Only) Claim Form Example</td>
<td>Form CH.29, Section 9 of this handbook</td>
</tr>
<tr>
<td>Orthotic and Prosthetic Services (CCP Only) Claim Form Example</td>
<td>Form CH.30, Section 9 of this handbook</td>
</tr>
<tr>
<td>Physical Therapists (CCP Only) Claim Form Example</td>
<td>Form CH.31, Section 9 of this handbook</td>
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<tr>
<td>Private Duty Nurses (CCP Only) Claim Form Example</td>
<td>Form CH.32, Section 9 of this handbook</td>
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<tr>
<td>Request for Initial Outpatient Therapy (Form TP-1)</td>
<td>Form CH.12, Section 8 of this handbook</td>
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<tr>
<td>Request for Extension of Outpatient Therapy (Form TP-2) (2 Pages)</td>
<td>Form CH.13, Section 8 of this handbook</td>
</tr>
<tr>
<td>Psychiatric Inpatient Initial Admission Request Form</td>
<td>Form CH.9, Section 8 of this handbook</td>
</tr>
<tr>
<td>Inpatient Psychiatric Hospital/Facility (CCP Only) Claim Form Example</td>
<td>Form CH.26, Section 9 of this handbook</td>
</tr>
<tr>
<td>Psychiatric Inpatient Extended Stay Request Form</td>
<td>Form CH.10, Section 8 of this handbook</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Hospital (CCP Only) Claim Form Example</td>
<td>Form CH.27, Section 9 of this handbook</td>
</tr>
<tr>
<td>School Health and Related Services (SHARS) Claim Form Example</td>
<td>Form CH.33, Section 9 of this handbook</td>
</tr>
<tr>
<td>Speech-Language Pathologists (CCP Only) Claim Form Example</td>
<td>Form CH.34, Section 9 of this handbook</td>
</tr>
<tr>
<td>State and Federal Offices Communication Guide</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>
8. CONTACT TMHP

For a complete list of TMHP communications, refer to the TMHP Telephone and Address Guide (Vol. 1, General Information).

8.1 Automated Inquiry System (AIS)

AIS (1-800-925-9126, Option 1) is available 7 days a week, 23 hours a day, with scheduled downtime between 3 a.m. and 4 a.m., and is the main point of contact for client eligibility information. AIS requires the use of a touch-tone phone in order to access the system.

8.2 TMHP Website

Additional information about Medicaid enrollment, general customer service, and provider education/training is available on the TMHP website at www.tmhp.com.

8.3 (Dental) Information and Assistance

For assistance with claims, dental providers may contact a TMHP Contact Center representative on the Dental Inquiry Line (1-800-568-2460).

8.3.1 Dental Inquiry Line

The Dental Inquiry Line (1-800-568-2460) is available Monday through Friday, 7 a.m. to 7 p.m., Central Time, and is the main point of contact for information regarding dental services and appeals.

Any dental service claim denial may be appealed by telephone if it was not denied as an incomplete claim and does not require one of the following items or conditions:

- Narratives
- Radiographs
- Models
- Other tangible documentation
- Review by the TMHP Dental Director

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>THSteps Dental Mandatory Prior Authorization Request Form Claim Form Example</td>
<td>Form CH.14, Section 8 of this handbook</td>
</tr>
<tr>
<td>CCP ECI Request for Initial/Renewal Outpatient Therapy Claim Form Example</td>
<td>Form CH.3, Section 8 of this handbook</td>
</tr>
<tr>
<td>CCP Prior Authorization Request Form</td>
<td>Form CH.1, Section 8 of this handbook</td>
</tr>
<tr>
<td>CCP Prior Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services (2 Pages)</td>
<td>Form CH.18, Section 8 of this handbook</td>
</tr>
<tr>
<td>Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services–Comprehensive Care Program (CCP)</td>
<td>Form CH.19, Section 8 of this handbook</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services) (6 Pages)</td>
<td>Form CH.20, Section 8 of this handbook</td>
</tr>
</tbody>
</table>
8.4 (THSteps) Information and Assistance

Providers with questions, concerns, or problems about claims should contact the TMHP Contact Center (1-800-925-9126). For contact information for their regional TMHP Provider Representative, providers can refer to the TMHP website at www.tmhp.com. Click on the Regional Support link.

8.4.1 THSteps Inqiy Line

The THSteps Medical Inquiry Line (1-800-757-5691) is available Monday through Friday, 7 a.m. to 7 p.m., Central Time, and is the main point of contact for information regarding THSteps medical services.

8.5 Assistance with Program

Providers with questions, concerns, or problems with program rules, policies, or procedures should contact DSHS regional program staff. THSteps staff contact numbers can be found in Appendix A, subsection A.6, “DSHS Health Service Region Contacts” (Vol. 1, General Information), on the THSteps website at www.dshs.state.tx.us/thsteps/default.shtm, or by calling THSteps (1-512-458-7745).

THSteps regional staff make routine contact with providers to educate and assist them with THSteps policies and procedures.

Clients who are eligible for Medicaid and have questions about THSteps, need to locate medical or dental providers, or need assistance with arranging transportation to appointments should call the THSteps Hotline (1-877-847-8377). Clients with questions about their Medicaid eligibility for THSteps should be directed to their caseworker at the local HHSC office or site.

9. FORMS
## CCP Prior Authorization Request Form

*If any portion of this form is incomplete, it will be returned.*

<table>
<thead>
<tr>
<th>Request for:</th>
<th>DME</th>
<th>Supplies</th>
<th>Private Duty Nursing</th>
<th>Inpatient Rehabilitation</th>
<th>Other</th>
</tr>
</thead>
</table>

**Client Information**

<table>
<thead>
<tr>
<th>Client Name (Last, First, MI):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Number (PCN):</td>
<td>Date of Birth: / /</td>
</tr>
</tbody>
</table>

**Supplier/Vendor Information**

<table>
<thead>
<tr>
<th>Supplier Name:</th>
<th>Telephone:</th>
<th>Fax Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplier Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
<td>Taxonomy:</td>
</tr>
<tr>
<td>Benefit Code:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Diagnosis and Medical Necessity of Requested Services**

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>From: / /</th>
<th>To: / /</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Brief Description of requested Services</th>
<th>Retail Price</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Note:** HCPCS codes and descriptions must be provided.

**Primary Practitioner’s Certifications**—To be completed by the primary practitioner

- By prescribing the identified DME and/or medical supplies, I certify to the following:
  - The client is under 21 years of age AND
  - The prescribed items are appropriate and can safely be used by the client when used as prescribed
  - For Private Duty Nursing, I certify:
    - The client’s medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

<table>
<thead>
<tr>
<th>Signature of prescribing physician:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed or typed name of physician:</td>
<td>TPI:</td>
</tr>
<tr>
<td>NPI:</td>
<td>License Number:</td>
</tr>
</tbody>
</table>

**Contact Information for Completed Forms**

<table>
<thead>
<tr>
<th>Fax Number:</th>
<th>1-512-514-4212</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address:</td>
<td>CCP</td>
</tr>
<tr>
<td></td>
<td>PO Box 200735</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0735</td>
</tr>
</tbody>
</table>

For TMHP Use Only

Effective Date: 07/30/2007
Revised Date: 06/29/2007

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CH.1 CCP Prior Authorization Request Form

CHILDREN'S SERVICES HANDBOOK
CH.2  CCP Prior Authorization Private Duty Nursing 6-Month Authorization

Client name:  Client Medicaid number:  Date: / /  

The following criteria must be met before seeking a 6-month authorization of private duty nursing (PDN) services. Remember that authorization is a condition for reimbursement; it is not a guarantee. Each nurse provider should verify the continued Medicaid coverage for each client for each month of service.

☐ Client has received PDN services for at least 3 months.

☐ Client has had no new significant diagnosis, treatment, illness/injury or hospitalization in at least 6 months that would be expected to affect the need for PDN services.

☐ Client’s physician and client/parent/guardian do not anticipate any significant changes in the client’s condition for the requested authorization period.

☐ The nurse provider will ensure that a new physician plan of care is obtained within 30 calendar days of the authorization expiration date and will be maintained with the client’s record.

☐ The nurse provider will advise TMHP-CCP of any significant changes in the client’s condition, treatments or physician orders which occur during the authorization period if the number of PDN hours needs to change.

☐ The client’s physician, client/parent/guardian, and nurse provider understand that the authorization may be changed during the authorization period if the client’s condition or skilled needs change significantly.

All required acknowledgments must be signed and dated

I have read and understand the above information. / /  

Signature of the client/parent/guardian  Date

Brief statement of why a maximum 6-month recertification is appropriate for this client:

I have discussed the above information with the client/parent/guardian. / /  

Signature of nurse provider  Date

To be completed by the client’s physician

Fax number:  

Mailing address  City, State, and ZIP code

Fax completed request to TMHP-CCP at 1-512-514-4212

Effective Date_09012007/Revised Date_04262010
## CCP ECI Request for Initial/Renewal Outpatient Therapy

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Medicaid number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the child received therapy in the last year from the public school system?</td>
<td>Yes</td>
</tr>
<tr>
<td>Date of Initial Evaluation PT:</td>
<td>OT:</td>
</tr>
<tr>
<td>Diagnoses:</td>
<td></td>
</tr>
</tbody>
</table>

### Requested Treatment Plan
Indicate the date(s) of service and frequency per week or month:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service Date(s)</th>
<th>Frequency per week</th>
<th>Frequency per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ PT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ OT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ SLP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### New Application
Have treatment goals been developed? Yes | No
Is the child capable of making measurable progress? Yes | No

### Renewal Application
Has the child made measurable progress during this period? Yes | No
Is the child capable of making continued measurable progress during this period? Yes | No

### Provider Information

#### Physician Information
Signature: | Date: / /
Name (printed): | TPI No.: | NPI No.:

#### PT Therapist Information
Signature: | Date: / /
Name (printed): | Telephone: |
Address: | TPI: | NPI: |
Taxonomy: | Benefit Code: |

#### OT Therapist Information
Signature: | Date: / /
Name (printed): | Telephone: |
Address: | TPI: | NPI: |
Taxonomy: | Benefit Code: |

#### SLP Therapist Information
Signature: | Date: / /
Name (printed): | Telephone: |
Address: | TPI: | NPI: |
Taxonomy: | Benefit Code: |
This certification is required by section 32.024 of the Human Resources Code and must be completed before the DME provider can be paid for durable medical equipment provided to a Medicaid client.

Esta certificación es necesaria bajo la Sección 32.024 del Código de Recursos Humanos y se debe llenar antes de pagarle al proveedor de equipo médico duradero por el equipo entregado al cliente de Medicaid.

**Section A: Client Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Medicaid ID Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>City:</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>Alternate Telephone Number:</td>
</tr>
</tbody>
</table>

**Section B: Provider Information**

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Prior Authorization Number (PAN):</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI/API:</td>
<td>TPI:</td>
</tr>
</tbody>
</table>

**Section C: Product Information**

<table>
<thead>
<tr>
<th>Date of Service:</th>
<th>Procedure Code:</th>
<th>Description:</th>
<th>Serial No.:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Code:</td>
<td>Description:</td>
<td>Serial No.:</td>
<td></td>
</tr>
<tr>
<td>Procedure Code:</td>
<td>Description:</td>
<td>Serial No.:</td>
<td></td>
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<tr>
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<td>Serial No.:</td>
<td></td>
</tr>
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<td>Description:</td>
<td>Serial No.:</td>
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</table>

**Section D: Certification**

This is to certify that on (month/day/year) _______________________ the client received the __________________________ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client’s needs.

The client, parent, guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment’s proper use and maintenance.

Printed name of DME Supplier ______________________
Printed name of Client, Parent, Guardian, or Primary Caregiver ______________________

Signature of DME Supplier ______________________
Signature of Client, Parent, Guardian, or Primary Caregiver ______________________

**Section D (Optional) : Certification (Spanish)**

Este certifica que el: (mes/día/año) _______________________ el cliente recibió __________________________ (equipo) que el doctor recetó. El equipo fue adaptado correctamente para el cliente y satisface sus necesidades.

El cliente, padre, tutor o cuidador principal del cliente recibió entrenamiento e instrucción en el uso y mantenimiento correcto del equipo.

Nombre del proveedor de equipo médico duradero ______________________
Nombre del cliente, padre, tutor o cuidador principal ______________________

Firma del proveedor de equipo médico duradero ______________________
Firma del cliente, padre, tutor o cuidador principal ______________________

This form must be submitted to TMHP for DME products with an allowed amount of $2500 dollars or more. Submit this form with claim form or fax this form to 512-506-6615. Information submitted in this form must match the claim form. This form must be filled out completely; place none or N/A where applicable. Incomplete forms will be returned and will cause a delay in the verification and payment process. Failure to submit this form will affect claim payment.

Notice to Clients: You may be contacted to verify receipt of the equipment provided.

Aviso al cliente: Es posible que lo contactemos para verificar que recibió equipo.
(Page 2 of 3—Required only for requests containing six or more items)

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<th>Client Information</th>
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<td>Medicaid ID Number:</td>
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<tr>
<th>Provider Information</th>
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<td>Provider Name:</td>
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<td>Prior Authorization Number (PAN):</td>
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<td>NPI/API:</td>
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<th>Product Information (Continuation)</th>
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<td>Date of Service:</td>
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<tbody>
<tr>
<td>This is to certify that on (month/day/year) _______________________ the client received the ____________________________ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client’s needs.</td>
</tr>
<tr>
<td>The client, parent, guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment’s proper use and maintenance.</td>
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<tr>
<td>Printed name of DME Supplier</td>
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<tr>
<td>Signature of DME Supplier</td>
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<th>Certification (Spanish)</th>
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<tbody>
<tr>
<td>Esto certifica que el: (mes/día/año) _______________________ el cliente recibió ____________________________ (equipo) que el doctor recetó. El equipo fue adaptado correctamente para el cliente y satisface sus necesidades.</td>
</tr>
<tr>
<td>El cliente, padre, tutor o cuidador principal del cliente recibió entrenamiento e instrucción en el uso y mantenimiento correcto del equipo.</td>
</tr>
<tr>
<td>Nombre del proveedor del equipo médico duradero</td>
</tr>
<tr>
<td>Firma del proveedor del equipo médico duradero</td>
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</table>
Your provider has sent you some medical equipment. We want to make sure that you got what you wanted and that it works well. We need to talk to you about the equipment before we can pay for it.

**Call TMHP at 1-888-276-0702.**

Please call us toll-free at 1-888-276-0702 as soon as you can. We are open Monday through Friday from 8 a.m. to 5 p.m., Central Time. If you call us after hours, you can leave a message. Tell us your name, phone number, and the best time to call you back.

**Required Information**

Please have this information with you when you call:

- Name
- Medicaid Number
- Date of birth
- Address (street, city, state, ZIP)
- Provider’s name
- Date you got the equipment
- Details about the equipment

Su proveedor le envió equipo médico. Queremos saber si recibió lo que pidió y si funciona bien. Necesitamos hablar con usted sobre este equipo antes de que paguemos por él.

**Llámenos al 1-888-276-0702.**

Por favor, llámenos gratis lo antes posible al 1-888-276-0702. Nuestras oficinas están abiertas de lunes a viernes, de 8 a.m. a 5 p.m., Hora del Centro. Si nos llama después de estas horas, puede dejar un mensaje con su nombre, número de teléfono y el mejor momento para volver a llamarlo.

**Información que necesitamos**

Cuando llame, tenga esta información a la mano:

- Nombre.
- Número de Medicaid.
- Fecha de nacimiento.
- Dirección (calle, ciudad, estado, código postal).
- Nombre del proveedor.
- Fecha en que recibió el equipo.
- Detalles sobre el equipo.
# Donor Human Milk Request Form

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Client Medicaid Number:</th>
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<tbody>
<tr>
<td>Date of birth:</td>
<td>Client’s weight:</td>
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</table>

Please include the Donor Human Milk Request Form along with the CCP Prior Authorization Request Form. Parts A and B of the Donor Human Milk Request Form must be completed and copies retained in both the physician’s and the milk bank’s records. These forms and clinical records are subject to retrospective review.

## Part A

The physician must keep up-to-date documentation of medical necessity and the signed written consent form in the child’s clinical record to be considered for Medicaid reimbursement.

- ☐ The medical necessity for breast milk* is:
  - Child’s diagnosis:

- Date of last feeding trial: / / 

- Reason donor milk is the only appropriate source of human milk for this client:

  *This information must be substantiated by written documentation in the clinical record of why the particular infant cannot survive and gain weight on any appropriate formula, such as an elemental formula or enteral nutritional product, other than donor human breast milk, and that a clinical feeding trial of an appropriate, nutritional product has been considered with each authorization.*

- ☐ The parent/guardian has signed and dated an informed consent that the risks and benefits of using banked donor human milk has been discussed with them.

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<thead>
<tr>
<th>Dates of service requested From:</th>
<th>To:</th>
<th>Quantity Requested:</th>
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<tbody>
<tr>
<td>Physician’s Signature:</td>
<td>Date: / /</td>
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<tr>
<td>Physician Name:</td>
<td>Physician’s Fax Number:</td>
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<td>License Number:</td>
<td>TPI:</td>
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<td>NPI:</td>
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## Part B

The particular donor human milk bank adheres to quality guidelines consistent with the Human Milk Banking Association of North America, or other standards established by HHSC.

- Yes ☐ No ☐

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<th>Milk Bank Name:</th>
<th>Milk Bank Fax Number:</th>
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<tr>
<td>Milk Bank Address:</td>
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<tr>
<th>Milk Bank Representative Signature</th>
<th>Date: / /</th>
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<tr>
<td>Milk Bank Representative’s Name:</td>
<td>TPI:</td>
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| NPI: | Taxonomy: | Benefit Code: |

*Effective Date_07302007/Revised Date_04/07/2010*
## CH.6 External Insulin Pump

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<th>Client Name:</th>
<th>Date of birth: / /</th>
<th>Medicaid number:</th>
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### Physician Information

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<th>Name:</th>
<th>Physician specialty:</th>
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<tr>
<th>Telephone:</th>
<th>Fax number:</th>
<th>License number:</th>
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The following information is the minimum documentation required for consideration of medical necessity and must be submitted with a completed and signed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

1. **Lab values**: current and past blood glucose levels, and glycosylated hemoglobin (Hb/A1C) levels—note date of lab draws

2. **Client history of severe glycemic excursions**, brittle diabetes, hypoglycemic/hyperglycemic reactions, nocturnal hypoglycemia, any extreme insulin sensitivity, and/or very low insulin requirements

3. **Client history of any wide fluctuations in blood glucose level before mealtimes**

4. **Client history of any dawn phenomenon** where fasting blood glucose level often exceeds 200 mg/dL

5. **Day-to-day variations in client’s work/school schedule, mealtimes and/or activity level, which require multiple insulin injections**

6. **For purchase after the initial trial period a statement of client’s compliance and effectiveness of the pump is required**

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<tr>
<th>Physician signature:</th>
<th>Date: / /</th>
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Effective Date: 07/30/2007; Revised Date: 06/01/2007
### Home Health Plan of Care (POC)

Write legibly or type. Claims will be denied if POC is illegible or incomplete.

<table>
<thead>
<tr>
<th>Client’s name:</th>
<th>Date of birth: / /</th>
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<tr>
<td>Date last seen by doctor: / /</td>
<td>Medicaid number:</td>
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</table>

#### Home Health Agency Information

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<tr>
<th>Name:</th>
<th>Fax number:</th>
<th>Telephone:</th>
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<td>Address:</td>
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<td>Taxonomy:</td>
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<td>DME TPI:</td>
<td>Benefit Code:</td>
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#### Physician Information

<table>
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<th>Name:</th>
<th>Telephone:</th>
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<td>TPI:</td>
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<tr>
<th>Status (check one):</th>
<th>New client ☐</th>
<th>Extension ☐</th>
<th>Revised Request ☐</th>
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<tbody>
<tr>
<td>Original SOC date: / /</td>
<td>Revised request effective date: / /</td>
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#### Services client receives from other agencies:

#### Diagnoses (include ICD-9 codes if PT/OT is ordered):

#### Function Limitations/Permitted Activities/Homebound Status:

#### Prescribed medications:

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<tr>
<th>Diet ordered:</th>
<th>Mental status:</th>
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<tr>
<td>Prognosis:</td>
<td>Rehabilitation potential:</td>
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#### Safety Precautions:

Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if PT/OT requested):

#### SNV visits requested:

#### HHA visits requested:

#### PT visits requested:

#### OT visits requested:

#### Supplies:

<table>
<thead>
<tr>
<th>DME Item No. 1</th>
<th>Own ☐ Repair ☐ Buy ☐ Rent ☐</th>
<th>How long is this DME item needed?</th>
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</thead>
<tbody>
<tr>
<td>DME Item No. 2</td>
<td>Own ☐ Repair ☐ Buy ☐ Rent ☐</td>
<td>How long is this DME item needed?</td>
</tr>
<tr>
<td>DME Item No. 3</td>
<td>Own ☐ Repair ☐ Buy ☐ Rent ☐</td>
<td>How long is this DME item needed?</td>
</tr>
<tr>
<td>DME Item No. 4</td>
<td>Own ☐ Repair ☐ Buy ☐ Rent ☐</td>
<td>How long is this DME item needed?</td>
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| RN signature: | Date signed: / / |

I anticipate home care will be required: From: / / To: / /

#### Conflict of Interest Statement

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program.

Check if this exception applies:

☐ Exception for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority) or exception for sole community Home Health Services agency as defined by 42CFR 424.22.

| Physician signature: | Date signed: / / |

Effective Date_07/30/2007/Revised Date_06/29/2007
### Documentation Requirements
All of the following documents must be complete and received by Texas Medicaid Healthcare Partnership (TMHP) before review or authorization of PDN services can occur:

1. All components of the Nursing Addendum to Plan of Care (CCP) completed and submitted with
2. The Home Health Plan of Care (POC) form, and
3. CCP Prior Authorization Request Form *(additional information may be attached)*.

☐ If the client is under 18 years of age, he/she must reside with an identified responsible adult/parent/guardian who is either trained to provide nursing care, or is capable of initiating an identified contingency plan when the scheduled PDN is unexpectedly unavailable.

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<th>Name:</th>
<th>Relationship:</th>
<th>Telephone:</th>
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☐ The client has an identified contingency plan.

☐ The client has a primary physician who provides ongoing health care and medical supervision.

☐ The place(s) where PDN services will be delivered supports the health and safety of the client.

☐ If applicable, there are necessary backup utilities, communication, fire, and safety systems available and functional.

### 1. Nursing Care Plan Summary
PDN services are based on a nursing assessment and nursing care plan established by the nurse provider in collaboration with the physician, client, and family. The nursing care plan provides a systematic way to document care given, client responses to interventions, and progress toward the goals of care.

#### Problem list:

#### Goals of care:

#### Specific measurable outcomes:

#### Progress toward goals:

#### Additional comments:

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*Effective Date: 09/01/2007; Revised Date: 04/07/2010*
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<tr>
<th>Client name:</th>
<th>Medicaid number:</th>
<th>Date: / /</th>
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**2. Summary of Recent Health History**—For initial authorization or 90-day summary for extension of PDN services

Include recent hospitalizations, emergency room visits, surgery (may submit a discharge summary), illnesses, changes in condition, changes in medication or treatment, parent/guardian update, other pertinent observations.

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<td><strong>3. Rationale for PDN Hours</strong>—To either increase, decrease, or stay the same. Also address plans to decrease PDN hours.</td>
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4. Schedule of Services 24-hour Daily Flow Sheet, 00:00—05:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, O=other in-home resource(s), specify name above

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<th>Military Time</th>
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### 4. Schedule of Services 24-hour Daily Flow Sheet, 06:00—11:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

**Codes:** N=PDN hours, P=family (if family has volunteered), S=School/daycare, O=other in-home resource(s), specify name above

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List other in-home resources:

4. Schedule of Services 24-hour Daily Flow Sheet, 12:00—17:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, O=other in-home resource(s), specify name above

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4. Schedule of Services 24-hour Daily Flow Sheet, 18:00—23:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, O=other in-home resource(s), specify name above

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5. Acknowledgement

**Must be signed by the client/parent/guardian and the nurse provider.**

By signing this form, the client/parent/guardian and the nurse provider acknowledge:

- Discussion and receipt of information about the CCP Private Duty Nursing service,
- PDN services may increase, decrease, stay the same, or be terminated based on a client’s need for skilled care,
- PDN is not authorized for respite, child care, activities of daily living, or housekeeping,
- All required criteria from the first page of this addendum are met, and completed documentation is submitted to TMHP,
- Participation in the development of the Nursing Care Plan for this client, and
- Emergency plans are part of the client’s care plan and include telephone numbers for the client’s physician, ambulance, hospital, and equipment supplier and information on how to handle emergency situations.

The client/parent/guardian agrees to follow through with the plan of care as prescribed by the client’s physician.

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<td>Dates of service from:</td>
<td>/ /</td>
<td>to</td>
<td>/ /</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of client/parent/guardian</th>
<th>Printed name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of PDN nurse provider</td>
<td>Printed name</td>
<td>Date</td>
</tr>
<tr>
<td>Signature of prescribing physician</td>
<td>Printed name</td>
<td>Date</td>
</tr>
</tbody>
</table>
# Psychiatric Inpatient Initial Admission Request Form

**Telephone:** 1-800-213-8877  
**Fax:** 1-512-514-4211

## I. Identifying Information

<table>
<thead>
<tr>
<th>Medicaid Number</th>
<th>Date: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client Name</strong></td>
<td>Last:</td>
</tr>
<tr>
<td></td>
<td>First:</td>
</tr>
<tr>
<td><strong>Date of birth:</strong></td>
<td>/ /</td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sex:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Date of admission:</strong></td>
<td>/ /</td>
</tr>
<tr>
<td><strong>Time:</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Facility Information

<table>
<thead>
<tr>
<th><strong>Name:</strong></th>
<th></th>
<th><strong>Contact Person:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Address:</strong></td>
<td></td>
<td><strong>TPI:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>NPI:</strong></td>
<td></td>
<td><strong>Taxonomy:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Commitment Type:</strong></td>
<td></td>
<td><strong>Benefit Code:</strong></td>
<td></td>
</tr>
<tr>
<td><em>(If applicable)</em></td>
<td></td>
<td><strong>Effective Date:</strong></td>
<td>/ /</td>
</tr>
<tr>
<td><strong>County:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Judge:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Referral source:

- ☐ Admitting MD
- ☐ MH Professional
- ☐ Other (list):

### Current living arrangements:

- ☐ With parent(s)
- ☐ Group/foster home
- ☐ Other (list):

## II. Description of Health Status

### II.A. Primary symptom described in “specific observable behavior” that requires acute hospital care

(Include: precipitating events leading to admission)

### II.B. Other relevant clinical information, including inability to benefit from less restrictive setting

(Attach additional pages or documents, as necessary)

### II.C. Psychiatric medications

*(include total daily doses)*

### II.D. Present and past drug/alcohol usage:

<table>
<thead>
<tr>
<th><strong>Name of chemical</strong></th>
<th><strong>Current use?</strong></th>
</tr>
</thead>
</table>

### II.E. Past psychiatric treatment

1. **Number of previous inpatient admissions:** [ ]
2. **Dates of most recent inpatient stay:** / / to / /
3. Previous ambulatory/outpatient treatment (provider or facility, frequency) – If none, why:

### III. Current diagnosis (Axis I):

### IV. Additional diagnosis (Axis I and Axis II):

### V. Current functional assessment scores (DSM IV):

- **GAF:** [ ]

### VI. No. of hospital days requested:

- [ ] **Dates:** / / to / /

### VII. Aftercare plan:

| **Provider or Facility:** | **Frequency:** |

| **Signature (attending MD):** | **Date:** / / |
| **Print name:** | **Provider license number:** |
| **Provider TPI:** | **Provider NPI:** |

*Effective Date_07/30/2007/Revised Date_07/10/2007*
# CH.10 Psychiatric Inpatient Extended Stay Request Form

**Texas Medicaid Provider Procedures Manual: Vol. 2**

<table>
<thead>
<tr>
<th>I. Identifying Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Number:</td>
</tr>
<tr>
<td>Client Name</td>
</tr>
<tr>
<td>Date of birth:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>TPI:</td>
</tr>
<tr>
<td>Commitment Type: (If applicable)</td>
</tr>
<tr>
<td>County:</td>
</tr>
</tbody>
</table>

## IIA. Current status of primary symptoms that require continued acute hospital care

(Include: 1. Date of most recent occurrence; 2. Frequency; 3. Duration; 4. Severity)

## IIB. Other relevant clinical/diagnostic information about the patient from the past 72 hours

(Attach additional pages or documents, as necessary)

## IIC. Current psychiatric medication

(Include total daily doses)

## IID. Discharge criteria

1. 
2. 
3. 

## IIE. Describe treatment, contacts, plans (including outcome) with family, school, etc.

## III. Current diagnosis (Axis I):

## IV. Additional diagnosis (Axis I and Axis II):

## V. Current functional assessment scores (DSM IV):

GAF [ ]

## VI. No. of hospital days requested:

[ ] Dates: | / | / to | / | / |

Projected discharge date (required): | / | / |

## VII. Aftercare plan:

Provider or Facility:

Frequency:

Signature (attending MD): | Date: | / | / |

Print name: | Provider license number |

Provider TPI: | Provider NPI: |
# CH.11 Pulse Oximeter Form

## Client Name: Medicaid number:

### DME Provider Information

<table>
<thead>
<tr>
<th>Telephone:</th>
<th>Fax number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
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</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Equipment Information

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Product Name and Model Number</th>
<th>Retail Price</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>

**New device provided for purchase? □ Yes □ No**

**Equipment designated for clinical use only is not considered appropriate for use in the home**

*Note: Oxygen dependent is defined as ongoing, regular need for use of supplemental oxygen for a significant portion of the day to maintain oxygen saturation. This does not include: PRN use; use only when sick; use only when suctioning; use for desaturation that occurs only when crying; use for desaturation that occurs only with seizure activity.*

**The following information must be completed by the physician**

Diagnosis and Basis for Medical Necessity of requested services:

**Dates of Service requested for Prior Authorization**

<table>
<thead>
<tr>
<th>From: / /</th>
<th>To: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Client is ventilator and/or oxygen dependent**

**Client is ventilator dependent**

**Client is weaning from oxygen and/or a ventilator**

**Anticipated length of monitor need:**

<table>
<thead>
<tr>
<th>□ Months:</th>
<th>□ 1-3 years</th>
<th>□ More than 3 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Who will respond to the monitor alarm?**

**Can the patient’s medical needs be met with intermittent “spot check” of oxygen saturations? □ Yes □ No**

**What is the medical basis for need of continuous monitoring?**

**Is the client receiving any nursing services such as PDN, Home Health Visits, MDCP, CBA, or Private Insurance?**

Please indicate services:

**Number of hours/visits:**

**Signature:**

**Date: / /**

**Name (printed):**

**Telephone:**

**Address:**

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
<th>License number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

---

*Must be submitted with a CCP Prior Authorization Request Form*

Effective Date_01012009/Revised Date_04072010
### Request for Initial Outpatient Therapy (Form TP-1)

**Request For Initial Outpatient Therapy (Form TP-1)**

<table>
<thead>
<tr>
<th>CCP - Texas Medicaid &amp; Healthcare Partnership</th>
<th>Texas Medicaid &amp; Healthcare Partnership CSHCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 200735 Austin TX 78720-0735 1-800-846-7470</td>
<td>PO Box 200855 Austin TX 78720-0855 1-800-568-2413 or 1-512-514-3000 FAX: 1-512-514-4222</td>
</tr>
</tbody>
</table>

Medicaid Number: CSHCN Number:

**Client Name:** Date of birth: / / Telephone:

**Client Address:**

Has the child received therapy in the last year from the public school system? □ Yes □ No

**Date of Initial Evaluation**

<table>
<thead>
<tr>
<th>PT</th>
<th>OT</th>
<th>SLP</th>
</tr>
</thead>
</table>

**ICD-9 Code/Diagnosis:**

**Date of onset:**

### Category of Therapy Being Requested

**PT/OT for:**
- □ Developmental anomalies
- □ Pre-surgery
- □ Post-surgery
- □ Date of surgery
- □ Serial Casting
- □ Acute Episode of Chronic Condition

**New Condition**
- □ Specialty Clinic
- □ Home Program
- □ ADL (activities of daily living)
- □ Equipment Assessment
- □ Equipment Training

**Speech for:**
- □ Craniofacial
- □ Developmental Anomalies
- □ New Condition
- □ Post Cochlear Implant

### Check the service requested, indicate the date(s) of service and frequency per week or month:

Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service Date(s)</th>
<th>Frequency per week</th>
<th>Frequency per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>OT</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>SLP</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
</tbody>
</table>

**Procedure code(s) for therapy services:**

**Specialist**

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>PT Therapist</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>OT Therapist</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>SLP Therapist</td>
<td>/ /</td>
<td></td>
</tr>
</tbody>
</table>

**Provider Information**

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
</table>

**Medicaid Identifying Information**

<table>
<thead>
<tr>
<th>TPI</th>
<th>NPI</th>
<th>Taxonomy</th>
<th>Benefit Code</th>
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</thead>
</table>

**CSHCN Identifying Information**

<table>
<thead>
<tr>
<th>TPI</th>
<th>NPI</th>
<th>Taxonomy</th>
<th>Benefit Code</th>
</tr>
</thead>
</table>

**FOR OFFICE USE ONLY:**

Medicaid □ Yes □ No HMO □ Yes □ No Restrictions:

PAN# Valid To

Effective Date_07302007/Revised Date_06012007
**Request for Extension of Outpatient Therapy (Form TP-2)**

**Request for Extension of Outpatient Therapy (Form TP-2)**

<table>
<thead>
<tr>
<th>Medicaid Number:</th>
<th>CSHCN Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name:</td>
<td>Date of birth: / / Telephone:</td>
</tr>
<tr>
<td>Client Address:</td>
<td></td>
</tr>
<tr>
<td>Has the child received therapy in the last year from the public school system? ☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Date of Initial Evaluation PT OT SLP</td>
<td></td>
</tr>
<tr>
<td>A copy of the initial evaluation must be attached</td>
<td></td>
</tr>
<tr>
<td>ICD-9 Code/Diagnosis:</td>
<td>Date of onset:</td>
</tr>
</tbody>
</table>

**Category of Therapy Being Requested**

<table>
<thead>
<tr>
<th>PT/OT for:</th>
<th>☐ Developmental anomalies</th>
<th>☐ Pre-surgery</th>
<th>☐ Post-surgery</th>
<th>Date of surgery / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Cast Removal Date Removed / /</td>
<td>☐ Serial Casting</td>
<td>☐ Acute Episode of Chronic Condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ New Condition</td>
<td>☐ Specialty Clinic</td>
<td>☐ Home Program</td>
<td>☐ ADL (activities of daily living)</td>
<td></td>
</tr>
<tr>
<td>☐ Equipment Assessment</td>
<td>☐ Equipment Training</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Speech for:**

| ☐ Craniofacial | ☐ Developmental Anomalies | ☐ New Condition | ☐ Post Cochlear Implant |

**Check the service requested, indicate the date(s) of service and frequency per week or month:**

Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service Date(s)</th>
<th>Frequency per week</th>
<th>Frequency per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ PT</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>☐ OT</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>☐ SLP</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
</tbody>
</table>

**Procedure code(s) for therapy services:**

<table>
<thead>
<tr>
<th>Specialist</th>
<th>Name</th>
<th>Signature</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PT Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OT Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLP Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Provider Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
<th>Fax:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Medicaid Identifying Information</td>
<td></td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
<td>Taxonomy:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Identifying Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPI:</td>
</tr>
</tbody>
</table>

**FOR OFFICE USE ONLY:**

Medicaid ☐ Yes ☐ No HMO ☐ Yes ☐ No Restrictions:
<table>
<thead>
<tr>
<th>PAN#</th>
<th>Valid</th>
<th>To</th>
</tr>
</thead>
</table>

Medicaid Number:  
CSHCN Number:  
Client Name:  
Date of birth:  /  /

Current Functional Status:

<table>
<thead>
<tr>
<th>New Treatment Goals:</th>
</tr>
</thead>
</table>

Prior Dates of Service:  from  /  /  to  /  /

Prior Functional Status:

<table>
<thead>
<tr>
<th>Prior Treatment Goals:</th>
</tr>
</thead>
</table>

Prior Treatment Provided:

<table>
<thead>
<tr>
<th>Prior Treatment Provided:</th>
</tr>
</thead>
</table>

FORM TP-2  Page 2 of 2

Effective Date_07302007/Revised Date_06012007
**THSteps Dental Mandatory Prior Authorization Request Form**

Submit to:
THSteps Dental
Prior Authorization Unit
P0 Box 202917
Austin, TX 78720-2917

**Note: All information is required—print clearly or type**

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Medicaid Number:</td>
</tr>
<tr>
<td>Gender: ☐ M ☐ F</td>
</tr>
</tbody>
</table>

**Check the following diagnostic tools submitted for review with the authorization request:**

- ☐ Panorex
- ☐ FM X-ray
- ☐ Periapicals
- ☐ Documentation
- ☐ Photos
- ☐ Orthodontic case
- ☐ I certify all primary dentition have been exfoliated (D8080).

**Date of service diagnostic tools were produced:**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Tooth Number or Letter</th>
<th>Surface</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Proposed treatment plan:**

**Signature of dentist:**

<table>
<thead>
<tr>
<th>Date of Birth: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Printed or typed name of dentist:**

<table>
<thead>
<tr>
<th>Dentist telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dentist address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Performing Dentist Identifying Numbers**

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Effective Date_01112008/Revised Date_01112008
Criteria for Dental Therapy Under General Anesthesia

Total points needed to justify treatment under general anesthesia = 22.

<table>
<thead>
<tr>
<th>Age of client at time of examination</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than four years of age</td>
<td>8</td>
</tr>
<tr>
<td>Four and five years of age</td>
<td>6</td>
</tr>
<tr>
<td>Six and seven years of age</td>
<td>4</td>
</tr>
<tr>
<td>Eight years of age and older</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Requirements (Carious and/or Abscessed Teeth)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 teeth or one sextant</td>
<td>3</td>
</tr>
<tr>
<td>3-4 teeth or 2-3 sextants</td>
<td>6</td>
</tr>
<tr>
<td>5-8 teeth or 4 sextants</td>
<td>9</td>
</tr>
<tr>
<td>9 or more teeth or 5-6 sextants</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavior of Client**</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely negative–unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability</td>
<td>10</td>
</tr>
<tr>
<td>Somewhat negative–defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator’s hand, refusal to take radiographs</td>
<td>4</td>
</tr>
<tr>
<td>Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal responses and are not indications for treatment under general anesthesia</td>
<td>0</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

<table>
<thead>
<tr>
<th>Additional Factors**</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention**</td>
<td>15</td>
</tr>
<tr>
<td>Failed conscious sedation**</td>
<td>15</td>
</tr>
<tr>
<td>Medically compromising of handicapping condition**</td>
<td>15</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

I understand and agree with the dentist’s assessment of my child’s behavior.

PARENT/GUARDIAN SIGNATURE: ______________________________________________________ DATE: ________________

Clients in need of general anesthesia who do not meet the 22-point threshold, by report, will require prior authorization.

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the client’s chart. The client’s chart must be available for review by representatives of TMHP and/or HHSC.

PERFORMING DENTIST’S SIGNATURE: ______________________________________________________

DATE: ________________ License No. ____________________________

Effective Date_01012009/Revised Date_12172008
Medicaid Dental Policy Regarding Criteria for Dental Therapy Under General Anesthesia–Attachment 1

Purpose: To justify I.V. Sedation or General Anesthesia for Dental Therapy, the following documentation is required in the Child’s Dental Record.

Elements: Note those required* and those as appropriate**: 
1) The medical evaluation justifying the need for anesthesia
2) Description of relevant behavior and reference scale
3) Other relevant narrative justifying the need for general anesthesia.
4) Client’s demographics, including date of birth.
5) Relevant dental and medical history.
6) Dental radiographs, intraoral\perioral photography and/or diagram of dental pathology.
7) Proposed Dental Plan of Care.
8) Consent signed by parent\guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained.
10) The parent\guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist’s assessment of their child’s behavior.
11) Dentist’s attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand alone form.

“I attest that the client’s condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the client’s record and is available in my office.”

REQUESTING DENTIST’S SIGNATURE: ____________________________ DATE: ________________
The referral form assists in relaying correct and pertinent information to the person or agency receiving the referral. It may be mailed or hand-carried by the client. When the form is returned, it should be placed in the client’s record.

**Receiving/Referring Agencies**
The name and address of both agencies should be completed to allow communication if additional information is necessary and to return a completed referral. If the referral is to a physician and the client is not able to name the physician who will be seen, this space may be completed MD/DO.

**Identifying Information**
This section concerning patient information should be as complete as possible. This section will assist the receiving agency to locate the client.

**Reason for Referral**
This section should contain information which is relevant to the referral. It may contain an assessment with request for further evaluation, or a request for intervention by a physician, hospital, or other agency involved with the client. Other information pertinent to the referral, such as family history or involvement with other agencies, may also be included.

**Release of Information**
This section must be signed.

**Findings/Services Rendered**
This final section provided the receiving agency the vehicle with which to transmit information back to originator of referral. Form may be mailed or carried by the client.
CH.17  THSteps Referral Form

Referral date: ____________________

TO: Name and address of receiving agency or person
FROM: Name and address of person or referring agency

Client’s name: ___________________________ Social Security number: ___________________________
Address: ________________________________ Birth date: ____________ Sex: (M) (F)
Telephone: _______________________________ DIRECTIONS TO HOME: _________________________

REASON FOR REFERRAL:
__________________________________________________________________________

RETURN RESPONSE REQUESTED
__________________________________________________________________________

Signature/Title

Signature signifies receipt/knowledge of this referral and authorizes the referring agency to release information necessary for its completion, and the referring agency is released from all legal responsibility that may arise from this act.

Signature of Client/Parent/Guardian

FINDINGS AND SERVICES RENDERED:
__________________________________________________________________________

1) White - Receiving Agency
   Signature/Title

2) Yellow - Receiving Agency Response
   ____________________________

3) Pink - Client Record
   Date

Note: Instructions (L-29a) for use of Referral Form should accompany the document. (HHSC) L-29 Rev. (6/91)
**CCP Prior Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services**

Use this form for dates of service on or after January 1, 2009.

### Client Information

<table>
<thead>
<tr>
<th>First name:</th>
<th>Last name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid number (PCN):</th>
<th>Date of birth: <strong><strong>/</strong></strong>/_____</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address, city, and ZIP:

Diagnosis codes (ICD-9-CM):

### Certification

I attest that this client's health care is medically complex and multidisciplinary.

**Medically complex** is the health care needed by a Medicaid beneficiary achieves the designation of “medically complex” when the approved plan of care necessitates a clinical professional, practicing within the scope of their license and in the context of a medical home, coordinate ongoing treatment to ensure its safe and effective delivery.

**Multidisciplinary Care** is the coordination of clinician ordered medically necessary health care that requires the collaboration of two or more medical, educational, social, developmental or other professionals in order to properly devise and implement the clinician-developed plan of medical care. For Medicaid coverage, multidisciplinary health care must include medically necessary services provided by program-enrolled clinical providers. Development and implementation of the plan of medical care may, in addition, need to take into account other related care provided by nonclinical providers as required to address the overall health needs of a client.

DATE of my last Face-to-Face inpatient or outpatient evaluation and management visit with the client: ____/____/_____  

I request a six-month authorization from ____/____/_____ to _____/_____/____ for non-face-to-face care coordination services for the client named on this form. I attest that these services are essential to provide quality health care for the identified client. I request authorization for the following types of services in the stated six-month period (check all that apply):

- [ ] Non-face-to-face prolonged services (authorization and reimbursement are limited to a maximum of 90 minutes once per client per provider*).
- [ ] 99358
- [ ] 99359

* I understand that I may submit a statement of medical necessity or progress note with a claim or with this authorization form for consideration of authorization of services that exceed the Texas Medicaid Program limits indicated above. Documentation must support a significant change in the client’s clinical condition.

- [ ] Care plan oversight:
  - [ ] Home or other
  - [ ] Home health**
  - [ ] Hospice**
  - [ ] Nursing Facility
  - [ ] 99339
  - [ ] 99374
  - [ ] 99377
  - [ ] 99379
  - [ ] 99340
  - [ ] 99375
  - [ ] 99378
  - [ ] 99380

(Expiration and reimbursement are limited to one service a month per six-month authorization period without exception.)

** I attest that I am the clinician who signed the plan of care for the home health agency or hospice; I do not have a significant financial or contractual relationship with the home health agency or hospice. I am not the medical director or employee of the hospice; and I do not furnish services under any arrangement with the hospice (including volunteering).

- [ ] Team conferences (authorization and reimbursement are limited to a maximum of one service per six-month authorization period. Authorization of additional team conferences may be considered for a client when there is documentation on this form of a change in the client’s medical home provider.)
- [ ] 99367

---

Effective Date_10/24/2008/Revised Date_04/07/2010
Client Information

<table>
<thead>
<tr>
<th>First name:</th>
<th>Last name:</th>
</tr>
</thead>
</table>

Medicaid number (PCN):

Certification (continued)

I attest that I am the medical home provider for the client and, as such, in coordination with the family and client, I have generated or updated (within the prior 12 months), a comprehensive care plan for the client which is documented in the client’s medical record, has been shared with the family or client, and includes the following components, at a minimum:

- A current medical summary, encompassing all disciplines and all aspects of the client’s care, and containing key information about the client’s health (e.g., conditions, complexity, medications, allergies, past surgical procedures, etc.).
- A current list of the main concerns, issues, and problems as well as key strengths or assets and the related current clinical information including a list of all diagnoses with ICD-9-CM diagnosis codes. Planned action steps to improve or enhance health outcomes.
- Planned action steps and interventions to address the concerns and to sustain or build strengths, with the expected outcomes.
- Disciplines involved with the client’s care and how the multiple disciplines will work or are working together to meet the client’s needs. Explain how the multidisciplinary approach will benefit the client’s needs.
- Short-term and long-term goals with timeframes.

Documentation

One of the following forms of documentation must be submitted with this request in order to obtain prior authorization for non-face-to-face care coordination services:

- Formal and written care plan.
- A progress note detailing care coordination planning and activities.
- A letter stating medical necessity for care coordination, including information on the care plan and care coordination services.

Provider Information

<table>
<thead>
<tr>
<th>Clinician provider name:</th>
<th></th>
</tr>
</thead>
</table>

Medicaid TPI:  
NPI:  
Taxonomy code:  
Benefit code:  
Telephone number:  
Fax number:  
Address, city, and ZIP:  
Clinician provider signature:  
Date:  

Effective Date_10/24/2008/Revised Date_04/07/2010
### Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services–Comprehensive Care Program (CCP)

Use this form for dates of service on or after January 1, 2009.

<table>
<thead>
<tr>
<th>(Specialist must keep form on file)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Medicaid number:</td>
</tr>
<tr>
<td>Client name:</td>
</tr>
<tr>
<td>Date of birth: <strong><strong>/</strong></strong>/____</td>
</tr>
</tbody>
</table>

**Parts A and B of this form must be completed and the form retained in the specialist’s or subspecialist’s records. This form is subject to retrospective review.**

**Part A**

Reason for call:

The specialist’s or subspecialist’s medical opinion:

Recommended treatment or laboratory services:

<table>
<thead>
<tr>
<th>Physician’s signature:</th>
<th>Date: <strong><strong>/</strong></strong>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician name:</td>
<td>Physician’s fax number:</td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
</tbody>
</table>

**Part B**

<table>
<thead>
<tr>
<th>Referring medical home clinician:</th>
<th>Referring clinician’s telephone number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
</tbody>
</table>

Referring Clinician’s Authorization Number:

---

Effective Date_10/24/2008/Revised Date_03/18/2008
**Instructions**

A current wheelchair seating assessment conducted by a physician, physical or occupational therapist must be completed for purchase of or modifications (including new seating systems) to a customized wheelchair. Please attach manufacturer information, descriptions, and an itemized list of retail prices of all additions that are not included in base model price.

Complete Sections I-VI for manual wheelchairs. Complete Sections I-VII for power wheelchairs.

<table>
<thead>
<tr>
<th>Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name:</td>
</tr>
<tr>
<td>Last name:</td>
</tr>
<tr>
<td>Medicaid number:</td>
</tr>
<tr>
<td>Date of birth:</td>
</tr>
<tr>
<td>Diagnosis:</td>
</tr>
<tr>
<td>Height:</td>
</tr>
<tr>
<td>Weight:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I. Neurological Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicate client’s muscle tone: ☐ Hypertonic ☐ Absent ☐ Fluctuating ☐ Other</td>
</tr>
<tr>
<td>Describe client’s muscle tone:</td>
</tr>
<tr>
<td>Describe active movements affected by muscle tone:</td>
</tr>
<tr>
<td>Describe passive movements affected by muscle tone:</td>
</tr>
<tr>
<td>Describe reflexes present:</td>
</tr>
</tbody>
</table>
## II. Postural Control

<table>
<thead>
<tr>
<th></th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head control:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trunk control:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper extremities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower extremities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## III. Medical/Surgical History And Plans:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there history of decubitis/skin breakdown?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If yes, please explain:*

Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures, degree of spinal curvature, etc.): 

Describe other physical limitations or concerns (i.e., respiratory): 

Describe any recent or expected changes in medical/physical/functional status: 

If surgery is anticipated, please indicate the procedure and expected date: 

## IV. Functional Assessment:

<table>
<thead>
<tr>
<th>Ambulatory status:</th>
<th>Nonambulatory</th>
<th>With assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Community ambulatory</td>
</tr>
<tr>
<td>Indicate the client’s ambulation potential:</td>
<td>Expected within 1 year</td>
<td>Not expected</td>
</tr>
<tr>
<td></td>
<td>Expected in future within ___ years</td>
<td></td>
</tr>
</tbody>
</table>
### IV. Functional Assessment:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Dependency</th>
<th>Maximum Assistance</th>
<th>Moderate Assistance</th>
<th>Minimum Assistance</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheelchair Ambulation</td>
<td>Is client totally dependent upon wheelchair?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If no, please explain:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicate the client’s transfer capabilities:</td>
<td>☐ Maximum assistance</td>
<td>☐ Moderate assistance</td>
<td>☐ Minimum assistance</td>
<td>☐ Independent</td>
<td></td>
</tr>
<tr>
<td>Is the client tube fed?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes, please explain:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding</td>
<td>☐ Maximum assistance</td>
<td>☐ Moderate assistance</td>
<td>☐ Minimum assistance</td>
<td>☐ Independent</td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td>☐ Maximum assistance</td>
<td>☐ Moderate assistance</td>
<td>☐ Minimum assistance</td>
<td>☐ Independent</td>
<td></td>
</tr>
</tbody>
</table>

Describe other activities performed while in wheelchair:

### V. Environmental Assessment

Describe where client resides:

<table>
<thead>
<tr>
<th>Accessibility</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the home accessible to the wheelchair?</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Are ramps available in the home setting?</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

Describe the client’s educational/vocational setting:

<table>
<thead>
<tr>
<th>Accessibility</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the school accessible to the wheelchair?</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Are there ramps available in the school setting?</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

If client is in school, has a school therapist been involved in the assessment? ☐ Yes ☐ No

Name of school therapist:
### V. Environmental Assessment

Describe how the wheelchair will be transported:

Describe where the wheelchair will be stored (home and/or school):

Describe other types of equipment which will interface with the wheelchair:

### VI. Requested Equipment:

Describe client’s current seating system, including the mobility base and the age of the seating system:

Describe why current seating system is not meeting client’s needs:

Describe the equipment requested:

Describe the medical necessity for mobility base and seating system requested:

Describe the growth potential of equipment requested in number of years:

Describe any anticipated modifications/changes to the equipment within the next three years:

<table>
<thead>
<tr>
<th>Physician/Therapist’s name:</th>
<th>Physician/Therapist’s signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Therapist’s title:</td>
<td>Date:</td>
</tr>
<tr>
<td>Physician/Therapist’s telephone number:</td>
<td>( ) -</td>
</tr>
<tr>
<td>Physician/Therapist’s employer (name):</td>
<td>Physician/Therapist’s address (work or employer address):</td>
</tr>
</tbody>
</table>
### VII. POWER WHEELCHAIRS:

*Complete if a power wheelchair is being requested*

Describe the medical necessity for power vs. manual wheelchair:

*(Justify any accessories such as power tilt or recline)*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is client unable to operate a manual chair even when adapted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is self propulsion possible but activity is extremely labored?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>If yes, please explain:</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is self propulsion possible but contrary to treatment regimen?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>If yes, please explain:</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How will the power wheelchair be operated (hand, chin, etc.)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the client been evaluated with the proposed drive controls?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the client have any condition that will necessitate possible change in access or drive controls within the next five years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the client physically and mentally capable of operating a power wheelchair safely and with respect to others?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the caregiver capable of caring for a power wheelchair and understanding how it operates?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How will training for the power equipment be accomplished?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Physician/Therapist’s name:**

**Physician/Therapist’s signature:**

**Physician/Therapist’s title:**

**Date:**

**Physician/Therapist’s telephone number:** ( ) -

**Physician/Therapist’s employer (name):**

**Physician/Therapist’s address (work or employer address):**
# Home Health/CCP Measuring Worksheet

## General Information

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Client’s name:</td>
<td>Date of birth:</td>
</tr>
<tr>
<td>Client’s Medicaid number:</td>
<td>Height:</td>
</tr>
<tr>
<td>Date when measured:</td>
<td>Weight:</td>
</tr>
<tr>
<td>Measurer’s name:</td>
<td>Measurer’s telephone number:</td>
</tr>
</tbody>
</table>

## Measurements

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Top of head to bottom of buttocks</td>
</tr>
<tr>
<td>2</td>
<td>Top of shoulder to bottom of buttocks</td>
</tr>
<tr>
<td>3</td>
<td>Arm pit to bottom of buttocks</td>
</tr>
<tr>
<td>4</td>
<td>Elbow to bottom of buttocks</td>
</tr>
<tr>
<td>5</td>
<td>Back of buttocks to back of knee</td>
</tr>
<tr>
<td>6</td>
<td>Foot length</td>
</tr>
<tr>
<td>7</td>
<td>Head width</td>
</tr>
<tr>
<td>8</td>
<td>Shoulder width</td>
</tr>
<tr>
<td>9</td>
<td>Arm pit to arm pit</td>
</tr>
<tr>
<td>10</td>
<td>Hip width</td>
</tr>
<tr>
<td>11</td>
<td>Distance to bottom of left leg (popliteal to heel)</td>
</tr>
<tr>
<td>12</td>
<td>Distance to bottom of right leg (popliteal to heel)</td>
</tr>
</tbody>
</table>

## Additional Comments
10. CLAIM FORM EXAMPLES
HEALTH INSURANCE CLAIM FORM

1. MEDICARE [X] MEDICAID [ ] TRICARE [X] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA ELIGIBILITY [ ] OTHER [ ]

2. PATIENT’S NAME (Last Name, First Name, Middle Initial)
   Doe, John

3. PATIENT’S BIRTH DATE
   03 17 1997

4. INSURED’S NAME (Last Name, First Name, Middle Initial)
   Joe Harris

5. PATIENT’S ADDRESS (No., Street)
   920 Channing Way

6. PATIENT’S STATUS
   Single

7. INSURED’S ADDRESS (No., Street)
   111 Medical Way

8. INSURED’S NAME (Last Name, First Name, Middle Initial)
   Doe, John

9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)
   Jane Doe

10. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE
    I authorize the release of any medical or other information necessary to process this claim.

11. INSURED’S POLICY GROUP OR FECA NUMBER
    123456789

12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE
    I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

13. INSURED’S I.D. NUMBER (For Program in Item 1)
    9876543021

14. DATE OF CURRENT:
    01 10 2009

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.
    YES

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
    FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
    Samuel Jones, M.D.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
    FROM TO

19. RESERVED FOR LOCAL USE
    304 90

20. OUTSIDE LAB? $ CHARGES
    YES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
    H0005

22. MEDICARE RESUBMISSION CODE
    12345

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE
    FROM TO
    01 01 2009 01 01 2009

25. FEDERAL TANF I.D. NUMBER
    12345

26. PATIENT’S ACCOUNT NO.
    9876543021

27. SIGNATURE OF PHYSICIAN OR SUPPLIER
    Joe Harris

28. TOTAL CHARGE
    $ 6900

29. BALANCE DUE
    $ 0

30. SERVICE FACILITY LOCATION INFORMATION
    Chemical Dependency of Texas
    111 Medical Way
    Dallas, TX 75213

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.)

32. SERVICE FACILITY LOCATION INFORMATION
    Chemical Dependency of Texas
    111 Medical Way
    Dallas, TX 75213

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

CH.21 CH-256

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**CH.22 Comprehensive Outpatient Rehabilitation Facility (CORF) (CCP Only)**

**Rehabilitation Health Center**
2600 West Drive
Texarkana, TX 75503
903-555-1234

**Patient Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>Address</td>
<td>9504 Dale St., Houston, TX 77057</td>
</tr>
</tbody>
</table>

**Admission Details**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>03241996</td>
</tr>
<tr>
<td>Sex</td>
<td>F</td>
</tr>
</tbody>
</table>

**Diagnosis**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Type</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>424</td>
<td>Comp. Outpatient Therapy Eval.</td>
<td>01232009</td>
<td>01232009</td>
<td>1</td>
<td>Medicaid</td>
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<tr>
<td>440</td>
<td>Speech Therapy</td>
<td>01252009</td>
<td>01252009</td>
<td>1</td>
<td>Medicaid</td>
</tr>
<tr>
<td>420</td>
<td>Physical Therapy</td>
<td>01292009</td>
<td>01292009</td>
<td>1</td>
<td>Medicaid</td>
</tr>
</tbody>
</table>

**Total Charges**

Total Charges: 135.00

**Certifications**

The certifications on the reverse apply to this bill and are made a part hereof.
CH.23 Diagnosis and Treatment (Referral from THSteps Checkup)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE GWIS

2. PATIENT’S NAME (Last Name, First Name, Middle Initial)
   Doe, John

3. PATIENT’S BIRTH DATE
   04 1994

4. INSURED’S NAME (Last Name, First Name, Middle Initial)
   01 01 2009

5. PATIENT’S ADDRESS (No., Street)
   2608 Best Street

6. PATIENT RELATIONSHIP TO INSURED
   Self

7. INSURED’S ADDRESS (No., Street)
   31927

8. PATIENT STATUS
   Single

9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)
   01 01 2009

10. IS PATIENT’S CONDITION RELATED TO:
    a. EMPLOYMENT? (Current or Previous)
       YES
    b. AUTO ACCIDENT?
       YES
    c. OTHER ACCIDENT?
       YES

11. INSURED’S POLICY GROUP OR FECA NUMBER

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.

13. INSURED’S I.D. NUMBER
    (For Program in Item 1)
    123456789

14. DATE OF CURRENT:
    MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.
    a. b. a. b.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
    a. b. a. b.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
    Sidney Medical Clinic

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
    a. b. YES  NO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES
    YES  NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
    (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
    1 493 90

22. MEDICARE RESUBMISSION CODE
    (Orignial Ref. No.)

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE
    From To
    01 01 2009 01 01 2009

25. B. PLACE OF SERVICE
    99213

26. C. PROCEDEURES, SERVICES OR SUPPLIES
    (Exclude Unusual Circumstances)
    01 01 2009 01 01 2009

27. D. DIAGNOSIS POINTERS
    01 01 2009 01 01 2009

28. E. MODIFIER
    01 01 2009 01 01 2009

29. F. $ CHARGES
    01 01 2009 01 01 2009

30. G. TOTAL CHARGE
    01 01 2009 01 01 2009

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.

Signature on File

NUCC Instruction Manual available at: www.nucc.org

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

CH.24  Durable Medical Equipment (CCP Only)

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. 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.

2. PATIENT’S NAME (Last Name, First Name, Middle Initial) Doe, Jane M.

3. PATIENT’S BIRTH DATE 01/15/1998

4. PATIENT’S ADDRESS (No., Street) 1201 Carning Place

5. CITY Plano

6. STATE TX

7. ZIP CODE 75432

8. PATIENT’S STATUS Single

9. PATIENT’S ADDRESS (No., Street) 1201 Carning Place

10. CITY Plano

11. STATE TX

12. ZIP CODE 75432

13. PATIENT’S DATE OF BIRTH 01/15/1998

14. DATE OF CURRENT ISSUANCE 01/01/2009

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, INJURY (Accident) OR ILLNESS (First symptom) OR PREGNANCY (LMP)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Paul Burnes, M.D.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES

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

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER 999268123

24. A. RESOURCES OF SERVICE From To

25. FEDERAL TAX I.D. NUMBER

26. PATIENT’S ACCOUNT NO.

27. ACCEPT ASSIGNMENT for govt. claims are back

28. TOTAL CHARGE $ 135.00

29. AMOUNT PAID $ 120.00

30. BALANCE DUE $ 15.00

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.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # General Supply Company 1902 Bunker Hill Hillsboro, TX 74932

David Patton 01/10/2009

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

NUCC Instruction Manual available at: www.nucc.org

CH-259

CPT ONLY - COPYRIGHT 2009 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.
### CH.26 Inpatient Psychiatric Hospital/Facility (CCP Only)

#### The First Hospital
123 Oak Street
Austin, TX 78701
512-555-1234

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>876 Avenue A Austin TX 78701</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIRTH-DATE</td>
<td>01062009 01062009</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CODE</th>
<th>VALUE CODES</th>
<th>AMOUNT</th>
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</thead>
<tbody>
<tr>
<td>124</td>
<td>555.00</td>
<td>2775.00</td>
</tr>
<tr>
<td>250</td>
<td>102.00</td>
<td></td>
</tr>
<tr>
<td>300</td>
<td>438.00</td>
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</tr>
<tr>
<td>915</td>
<td>325.00</td>
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**Total Charges**: 3640.00

**Medicaid**

<table>
<thead>
<tr>
<th>INSURED'S NAME</th>
<th>123456789</th>
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<table>
<thead>
<tr>
<th>DATE</th>
<th>OCCURRENCE</th>
<th>OCCURRENCE</th>
<th>OCCURRENCE</th>
<th>SPAN</th>
<th>OCCURRENCE</th>
<th>OCCURRENCE</th>
<th>OCCURRENCE</th>
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<tbody>
<tr>
<td>01012001</td>
<td>F</td>
<td>14</td>
<td>3</td>
<td>1</td>
<td>15</td>
<td>01</td>
<td></td>
</tr>
</tbody>
</table>

**Admit Date**: 01012001

**Discharge Date**: 01062009

**Reason for Stay**: Depressive Disorder

---

The certifications on the reverse apply to this bill and are made a part hereof.
## CH.27 Inpatient Rehabilitation Hospital (CCP Only)

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Rate</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>128</td>
<td>Semi Private Room</td>
<td>01/01/2009</td>
<td>01/15/2009</td>
<td>400.00</td>
<td>5600.00</td>
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<tr>
<td>250</td>
<td>Pharmacy</td>
<td></td>
<td></td>
<td></td>
<td>298.63</td>
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<tr>
<td>270</td>
<td>Medical/Surgical Supplies</td>
<td></td>
<td></td>
<td></td>
<td>542.16</td>
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<tr>
<td>300</td>
<td>Laboratory</td>
<td></td>
<td></td>
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<td>210.28</td>
</tr>
<tr>
<td>420</td>
<td>Physical Therapy</td>
<td></td>
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<td></td>
<td>4878.00</td>
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<tr>
<td>430</td>
<td>Occupational Therapy</td>
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<td></td>
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<td>6878.00</td>
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<tr>
<td>910</td>
<td>Psychiatric Services - General</td>
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<td>1794.00</td>
</tr>
</tbody>
</table>

Total Charges: 20201.07
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE</th>
<th>CHAMPUS</th>
<th>CHAMPVA</th>
<th>HEALTH PLAN</th>
<th>FEDCA</th>
<th>GROUP</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Medicare)</td>
<td>(Medicaid)</td>
<td>(Tricare)</td>
<td>(Champus)</td>
<td>(Champva)</td>
<td>(Health Plan)</td>
<td>(Fedca)</td>
<td>(Group)</td>
<td>(Other)</td>
</tr>
</tbody>
</table>

2. **PATIENT’S NAME**
   - Last Name: Doe, Jane
   - First Name: Jill
   - Middle Initial: Brown

3. **PATIENT’S BIRTH DATE**
   - MM: 10
   - DD: 26
   - YY: 2007

4. **INSURED’S NAME**
   - Last Name: Smith
   - First Name: Jim
   - Middle Initial: M.

5. **PATIENT’S ADDRESS**
   - (No., Street): 1544 Brittany Trail
   - City: Austin
   - State: TX
   - Zip Code: 78728

6. **PATIENT RELATIONSHIP TO INSURED**
   - Spouse
   - Child

7. **INSURED’S ADDRESS**
   - (No., Street): 2010 Main Street
   - City: Austin
   - State: TX
   - Zip Code: 78728

8. **PATIENT STATUS**
   - Single
   - Married
   - Other

9. **OTHER INSURED’S NAME**
   - Last Name: Doe
   - First Name: Jane
   - Middle Initial: J.

10. **INSURED’S OR AUTHORIZED PERSON’S SIGNATURE**
    - I authorize the release of any medical or other information necessary to process this claim.

11. **INSURED’S POLICY GROUP OR FECA NUMBER**
    - (For Program in Item 1)
    - NPI: 9876543021
    - NPI: 1234567890

12. **PATIENT’S ACCOUNT NO.**
    - (For Program in Item 1)
    - 1234567890

13. **INSURED’S I.D. NUMBER**
    - (For Program in Item 1)
    - Medicare #: 1234567890
    - Medicaid #: 0123456789
    - Sponsor’s SSN: 1234567890
    - Member ID #: 1234567890
    - SSN: 1234567890

14. **DATE OF CURRENT ILLNESS OR INJURY**
    - (Explain Unusual Circumstances)
    - Date: 01 01 2009

15. **IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS**
    - YES
    - NO

16. **DAYS PATIENT IN CURRENT OCCUPATION**
    - YES
    - NO

17. **NAME OF REFERRING PROVIDER OR OTHER SOURCE**
    - Jim Smith, M.D.

18. **HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**
    - From: 01 01 2009
    - To: 01 01 2009

19. **RESERVED FOR LOCAL USE**
    - YES
    - NO

20. **OUTSIDE LAB?**
    - YES
    - NO

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

22. **CODING**
    - CPT/HCPCS: S9470

23. **SIGNATURE OF PHYSICIAN OR SUPPLIER**
    - (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

24. **DATE(S) OF SERVICE**
    - From: 01 01 2009
    - To: 01 01 2009

25. **SIGNATURE OR GLOBAL BILL ACCOUNT NO.**
    - Jill Brown
    - 01 10 2009

26. **TOTAL CHARGE**
    - $3000

27. **AMOUNT PAID**
    - $3000

28. **BALANCE DUE**
    - $0

29. **CARRIER PATIENT AND INSURED INFORMATION**

30. **PHYSICIAN OR SUPPLIER INFORMATION**

**CHILDREN’S SERVICES HANDBOOK**

CPT ONLY - COPYRIGHT 2009 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.
CH.29 Occupational Therapists (CCP Only)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CH-29 Occupational Therapists (CCP Only)

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

NUCC Instruction Manual available at: www.nucc.org

Health Insurance Claim Form

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Colin K. Smith, OT

01 10 2009

NPI

9876543021

1234567-01

CH-264

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# HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>MEDICAD</th>
<th>TRICARE</th>
<th>CHAMPVA</th>
<th>GROUP</th>
<th>HEALTH PLAN</th>
<th>FECA</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</th>
<th>3. PATIENT'S BIRTH DATE</th>
<th>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5. PATIENT'S ADDRESS (No., Street)</th>
<th>6. PATIENT RELATIONSHIP TO INSURED</th>
<th>7. INSURED'S ADDRESS (No., Street)</th>
</tr>
</thead>
<tbody>
<tr>
<td>563 Lake Ct.</td>
<td>Set Spouse Child Other</td>
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</table>

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>8. PATIENT STATUS</th>
<th>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharr</td>
<td>TX</td>
<td>Single Married Other</td>
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<table>
<thead>
<tr>
<th>ZIP CODE</th>
<th>TELEPHONE (Include Area Code)</th>
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<tbody>
<tr>
<td>75235</td>
<td>( )</td>
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</table>

<table>
<thead>
<tr>
<th>10. IS PATIENT'S CONDITION RELATED TO:</th>
<th>11. INSURED'S POLICY GROUP OR FECA NUMBER</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</th>
<th>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I authorize the release of any medical or information necessary to process this claim. I also request payment of medical benefits to the undersigned physician or supplier for services described below.</td>
<td>I authorize the release of any medical or information necessary to process this claim. I also request payment of medical benefits to the undersigned physician or supplier for services described below.</td>
</tr>
</tbody>
</table>

**Signature on File**

<table>
<thead>
<tr>
<th>14. DATE OF CURRENT ILLNESS</th>
<th>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</th>
<th>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</th>
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</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td>GIVE FIRST DATE MM DD YY</td>
<td>MM DD YY MM DD YY</td>
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<tr>
<td>01 01 2009</td>
<td>L1960</td>
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<table>
<thead>
<tr>
<th>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joanne Wallace, M.D.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>FROM MM DD YY TO MM DD YY</td>
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<table>
<thead>
<tr>
<th>19. RESERVED FOR LOCAL USE</th>
<th>20. OUTSIDE LAB?</th>
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<tbody>
<tr>
<td></td>
<td>$ CHARGES</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</th>
<th>22. MEDICAD RESUBMISSION CODE</th>
<th>23. PRIOR AUTHORIZATION NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Relate Items 1, 2, 3, 4, 5 to Item 24E by Line)</td>
<td>ORIGINAL REF. NO.</td>
<td>1234567890</td>
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<table>
<thead>
<tr>
<th>24. DAYS OF SERVICE</th>
<th>25. PROCEDURE SERVICES OR SUPPLIES</th>
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</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td>EMG CPT/HCPCS MODIFIER</td>
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<table>
<thead>
<tr>
<th>26. PATIENT'S ACCOUNT NO.</th>
<th>27. ACCEPT ASSIGNMENT</th>
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<td></td>
<td>YES</td>
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<table>
<thead>
<tr>
<th>28. TOTAL CHARGE</th>
<th>29. AMOUNT PAID</th>
<th>30. BALANCE DUE</th>
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<tbody>
<tr>
<td>$88735</td>
<td>$</td>
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**Signature on File**

<table>
<thead>
<tr>
<th>SIGNED DATE</th>
<th>SIGNATURE OF PHYSICIAN OR SUPPLIER INFORMATION</th>
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<tbody>
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<td>01 10 2009</td>
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</table>

<table>
<thead>
<tr>
<th>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</th>
<th>32. SERVICE FACILITY LOCATION INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</td>
<td></td>
</tr>
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</table>

**CH.30 Orthotic and Prosthetic Services (CCP Only)**

NUCC Instruction Manual available at: www.nucc.org
### CH.31 Physical Therapists (CCP Only)

**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/95**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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<tbody>
<tr>
<td>1. MEDICARE</td>
<td>Medicare # [X], Medicaid # [ ]</td>
</tr>
<tr>
<td>2. PATIENT'S NAME</td>
<td>Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>3. PATIENT'S BIRTH DATE</td>
<td>MM DD YY</td>
</tr>
<tr>
<td>4. INSURED'S NAME</td>
<td>Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>5. PATIENT'S ADDRESS</td>
<td>(No., Street)</td>
</tr>
<tr>
<td>6. PATIENT'S BIRTH DATE</td>
<td>MM DD YY</td>
</tr>
<tr>
<td>7. INSURED'S ADDRESS</td>
<td>(No., Street)</td>
</tr>
<tr>
<td>8. PATIENT'S STATUS</td>
<td>Single, Married, Other</td>
</tr>
<tr>
<td>9. OTHER INSURED'S NAME</td>
<td>Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>10. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</td>
<td>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.</td>
</tr>
<tr>
<td>11. INSURED'S POLICY GROUP OR FECA NUMBER</td>
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</tr>
<tr>
<td>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</td>
<td>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.</td>
</tr>
<tr>
<td>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</td>
<td>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.</td>
</tr>
<tr>
<td>14. DATE OF CURRENT ILLNESS</td>
<td>MM DD YY</td>
</tr>
<tr>
<td>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</td>
<td></td>
</tr>
<tr>
<td>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td>MM DD YY</td>
</tr>
<tr>
<td>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
<td>David Jones, M.D.</td>
</tr>
<tr>
<td>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td>FROM TO</td>
</tr>
<tr>
<td>19. RESERVED FOR LOCAL USE</td>
<td></td>
</tr>
<tr>
<td>20. OUTSIDE LAB?</td>
<td>YES [X] NO [ ]</td>
</tr>
<tr>
<td>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Explain Unusual Circumstances)</td>
<td></td>
</tr>
<tr>
<td>22. MEDICAID RESUBMISSION CODE</td>
<td>ORIGINAL REF. NO.</td>
</tr>
<tr>
<td>23. PRIOR AUTHORIZATION NUMBER</td>
<td></td>
</tr>
<tr>
<td>24. A. DATES(S) OF SERVICE</td>
<td>FROM TO</td>
</tr>
<tr>
<td>B. PLACE OF SERVICE</td>
<td>PLACES OF SERVICE</td>
</tr>
<tr>
<td>C. PROCEDURES, SERVICES, OR SUPPLIES</td>
<td>EXPENSE OR SUPPLIES</td>
</tr>
<tr>
<td>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</td>
<td>EXPENSE OR SUPPLIES</td>
</tr>
<tr>
<td>E. DIAGNOSIS</td>
<td>DIAGNOSIS</td>
</tr>
<tr>
<td>25. FEDERAL TAX I.D. NUMBER</td>
<td>SSN, SIN</td>
</tr>
<tr>
<td>26. PATIENT'S ACCOUNT NO.</td>
<td>12345</td>
</tr>
<tr>
<td>27. ACCEPT ASSIGNMENT</td>
<td>YES [X] NO [ ]</td>
</tr>
<tr>
<td>28. TOTAL CHARGE</td>
<td>$</td>
</tr>
<tr>
<td>29. AMOUNT PAID</td>
<td>$</td>
</tr>
<tr>
<td>30. BALANCE DUE</td>
<td>$</td>
</tr>
<tr>
<td>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</td>
<td>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</td>
</tr>
<tr>
<td>32. SERVICE FACILITY LOCATION INFORMATION</td>
<td></td>
</tr>
<tr>
<td>33. BILLING PROVIDER INFO &amp; PH #</td>
<td>Larry Jones, 1242 Rosewood, Conroe, TX 77307</td>
</tr>
</tbody>
</table>

**Signature on File**

**SIGNED DATE**

**CPT/HCPCS MODIFIER**

**EMG**

**DIAGNOSIS**

**PLAN**

**QUAL.**

**POINTER**

**UNITS**

**DAYS**

**BILLING PROVIDER INFO & PH #**

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

**NUCC Instruction Manual available at:** www.nucc.org

---

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### CH.32 Private Duty Nurses (CCP Only)

**ABC Homebound Care**  
123 Main Street  
Austin, TX 78725

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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<tbody>
<tr>
<td>Doe, Jane</td>
<td>3201 Crow Road</td>
<td>78728</td>
<td>55555</td>
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**UB-04 CMS-1450**

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**Total Charges**: 2000

**Remarks**: Down Syndrome
CH.33 School Health and Related Services (SHARS)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDicare | MEDIcAID | TRICARE | CHAMPUS | CHAMPVA | GROUP | FEDERAL | OTHER

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

3. PATIENT'S ADDRESS (No., Street) 4420 Avenue C

4. PATIENT'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.

5. PATIENT'S DATE OF BIRTH M: 01 D: 02 Y: 1999 M: F X

6. PATIENT'S ADDRESS (No., Street) 4420 Avenue C

7. PATIENT'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.

8. PATIENT'S ADDRESS (No., Street) 4420 Avenue C

9. PATIENT'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.

10. PATIENT'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.

11. PATIENT'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.

12. PATIENT'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.

13. PATIENT'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.

14. DATE OF CURRENT:

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. MEDICAID RESUBMISSION

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES(S) OF SERVICE

25. MEDICARE RESUBMISSION

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT

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.)

32. SERVICE Facility LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

SIGNED DATE

SIGNED DATE

SIGNED DATE

SIGNED DATE

SIGNED DATE

SIGNED DATE

SIGNED DATE

SIGNED DATE
## HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>10. PATIENT'S NAME</th>
<th>Last Name, First Name, Middle Initial</th>
<th>20. INSURED'S POLICY GROUP OR FECA NUMBER</th>
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<tbody>
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<td>Doe, Jane</td>
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<td>123456789</td>
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<tr>
<td>506 Unterhalt Street</td>
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<tr>
<td>78218</td>
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**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**

---

**Signatures on File**

- **Karen Belman, M.D.**
- **1234567089**
- **1234567890**

**Medicare Resubmission Code**

- **Original Ref. No.:**
- **1234567890**

**Provider ID #:**

- **9087564321**
- **1234567-01**

---

**CARRIERS**

**PATIENT AND INSURED INFORMATION**

**PHYSICIAN OR SUPPLIER INFORMATION**

**NUCC Instruction Manual available at: www.nucc.org**

---

**CHILDREN'S SERVICES HANDBOOK**

---

**CHILD.34 Speech-Language Pathologists (CCP Only)**
**HEALTH INSURANCE CLAIM FORM**

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<td>2. PATIENT’S NAME</td>
<td>Doe, Jane</td>
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<tr>
<td>3. PATIENT’S BIRTH DATE</td>
<td>01 15 2005</td>
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<tr>
<td>4. INSURED’S NAME</td>
<td>Doe, Jane</td>
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<tr>
<td>9. OTHER INSURED’S NAME</td>
<td>Doe, John</td>
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<tr>
<td>10. IS PATIENT’S CONDITION RELATED TO:</td>
<td>YES</td>
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<td>11. INSURED’S POLICY GROUP OR FECA NUMBER</td>
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<tr>
<td>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
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<tr>
<td>20. OUTSIDE LAB? $ CHARGES</td>
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<tr>
<td>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Medicare &amp; Medicaid)</td>
<td>V202</td>
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<td>22. MEDICAID RESUBMISSION CODE</td>
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<td>24. A. DATES OF SERVICE</td>
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<td>25. FEDERAL TAX I.D. NUMBER</td>
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<td>26. PATIENT’S ACCOUNT NO.</td>
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<td>27. ACCEPT ASSIGNMENT</td>
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<td>28. TOTAL CHARGE</td>
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<td>32. SERVICE FACILITY LOCATION INFORMATION</td>
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<tr>
<td>33. BILLING PROVIDER INFO &amp; PH #</td>
<td>Star Community Health Center</td>
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</table>

**MEDICAID OF TX**

**APPROVED FORM CMS-1500 (08/05)**

**PHYSICIAN or SUPPLIER INFORMATION**

**SIGNED DATE**

**CARRIERS**

**PICA**

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

**CH-270**

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**CH.36 THSteps Established Patient and Referral, TB Skin Test, and Physical Examination by a Physician**

**1500**

**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

**MEDICAID OF TX**

**PO BOX 200555**

**AUSTIN, TX 78720-0555**

<table>
<thead>
<tr>
<th>ITEM</th>
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<tr>
<td>1.</td>
<td>MEDICARE</td>
<td>MEDICAID</td>
</tr>
<tr>
<td>2.</td>
<td>TRICARE CHAMPUS</td>
<td>CHAMPVA</td>
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<tr>
<td>3.</td>
<td>GROUP HEALTH PLAN (ISSN or ID)</td>
<td>FPCA (ISSN or ID)</td>
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<tr>
<td>4.</td>
<td></td>
<td>OTHER</td>
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<tr>
<td>1a.</td>
<td>INSURED'S S.I.D. NUMBER</td>
<td>(For Program in Item 1)</td>
</tr>
<tr>
<td>1b.</td>
<td>INSURED'S S.I.D. NUMBER</td>
<td>(For Program in Item 2)</td>
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<tr>
<td>1c.</td>
<td>INSURED'S S.I.D. NUMBER</td>
<td>(For Program in Item 3)</td>
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<tr>
<td>1d.</td>
<td>INSURED'S S.I.D. NUMBER</td>
<td>(For Program in Item 4)</td>
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**2. PATIENT'S NAME (Last Name, First Name, Middle Initial)**

Doe, John

**3. PATIENT'S BIRTH DATE**

MM DD YY

02 01 1999 M X F

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

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

500 24th Place

**6. PATIENT'S STATUS**

Single X Married Other

**7. CITY, STATE**

Lubbock, TX

**8. PATIENT'S SIGNATURE**

Signed Date

01/20/2009

Signature on File

01/20/2009

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

**10. INSURED'S POLICY GROUP OR FECA NUMBER**

**11. INSURED'S I.D. NUMBER**

Medicare # Medicaid # Sponsor's SSN (Member ID)

**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.

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.

**13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE**

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

**14. DATE OF CURRENT OCCUPATION**

MM DD YY

**15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.**

**16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**

**17. NAME OF REFERRING PROVIDER OR OTHER SOURCE**

**18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**

**19. RESERVED FOR LOCAL USE**

**20. OUTSIDE LAB? $ CHARGES**

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

**22. MEDICAID RESUBMISSION CODE**

**23. PRIOR AUTHORIZATION NUMBER**

**24. A. DATES OF SERVICE**

**25. FEDERAL TAX I.D. NUMBER**

**26. PATIENT'S ACCOUNT NO.**

**27. ACCEPT ASSIGNMENT?**

**28. TOTAL CHARGE**

**29. AMOUNT PAID**

**30. BALANCE DUE**

**31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS**

**32. SERVICE FACILITY LOCATION INFORMATION**

**33. BILLING PROVIDER INFO & PH #**

Carl Kidd, M.D., and Associates

3301 Hill Lane

Lubbock, TX 79488

**34. SIGNATURE OF PHYSICIAN OR SUPPLIER**

**35. SIGNATURE OF PAYOR**

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11. APPENDICES