OUTPATIENT SERVICES HANDBOOK

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Note: A comprehensive Index, including Volume 1 and all handbooks from Volume 2, is included at the end of Volume 1 (General Information).
1. GENERAL INFORMATION

This information is intended for ambulatory surgical centers (ASCs), hospital ambulatory surgical centers, (HASCs), Federally Qualified Health Centers (FQHCs) renal dialysis facilities, Rural Health Clinics (RHCs) and tuberculosis (TB) clinics. This 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 healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 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.

1.1 National Drug Codes (NDC)


2. AMBULATORY SURGICAL CENTER AND HOSPITAL AMBULATORY SURGICAL CENTER

2.1 Enrollment

To enroll in Texas Medicaid, an ASC must do the following:

- Meet and comply with applicable state and federal laws, rules, regulations, and provisions of the state plan under Title XIX of the Social Security Act
- Be enrolled in Medicare
- Meet and comply with state licensure requirements for ASCs

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

All hospitals enrolling in Texas Medicaid (except psychiatric and rehabilitation hospitals) are issued an ASC provider number at the time of enrollment.

An out-of-state provider may enroll in Texas Medicaid if it is the customary or general practice for clients in a particular locality to use medical resources in another state. An out-of-state provider located within 50 miles of the Texas border is automatically considered to meet this criterion.
Refer to: Subsection 1.1, “Provider Enrollment” in Section 1, Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about enrollment procedures.

Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in Radiology, Laboratory, and Physiological Lab Services Handbook (Vol. 2, Provider Handbooks).

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

2.2 Services/Benefits, Limitations, and Prior Authorization

2.2.1 American Society of Anesthesiologists (ASA) Physical Status and New York Heart Association Heart Disease Classifications

A client with either an ASA Classification of Physical Status of I (P1) or II (P2), or New York Heart Association Functional Classification of Heart Disease I, II, or III is considered suitable for ASC or HASC care. Clients with an ASA Classification of Physical Status of III (P3), IV (P4), or V (P5) or New York Heart Association Functional Classification of Heart Disease IV should be considered for inpatient status.

The description of ASA classes is as follows:

- **Class I.** A normal, healthy patient, without organic, physiologic, or psychiatric disturbance.
- **Class II.** A patient with mild systemic disease, controlled medical conditions without significant systemic effects.
- **Class III.** A patient exhibiting severe systemic disturbance that may or may not be associated with the surgical complaint and that seriously interferes with the patient’s activities.
- **Class IV.** A patient exhibiting extreme systemic disturbance that may or may not be associated with the surgical complaint that interferes with the patient’s regular activities, and that has already become life-threatening.
- **Class V.** The rare person who is moribund (in a dying state) before operation, whose preoperative condition is such that he or she is expected to die within 24 hours even though not subjected to the additional strain of the operation.

Heart Disease classifications are described below:

- **Class I.** No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.
- **Class II.** Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.
- **Class III.** Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.
- **Class IV.** Unable to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency, or of the anginal syndrome, may be present even at rest. If any physical activity is undertaken, discomfort occurs.

2.2.2 Drugs and Supplies

Outpatient prescribed medications are a benefit to eligible clients when obtained through a pharmacy contracted with the Medicaid Vendor Drug Program. Prescribed take-home supplies are a benefit to eligible clients when obtained through Medicaid durable medical equipment (DME).

Refer to: Appendix B, “Vendor Drug Program” (Vol. 1, General Information) for information about outpatient prescription drugs and the Medicaid Vendor Drug Program.

Subsection 1.2.3, “Medical Supplies” in Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks).
2.2.3 Incomplete Surgical Procedures
When an ASC or HASC bills Texas Medicaid for an incomplete surgical procedure, one of the following must be included on the claim:

- Modifier 73 for a discontinued outpatient procedure after anesthesia administration
- Modifier 74 for a discontinued outpatient procedure before anesthesia administration
- At least one of the following diagnosis codes: V641, V642, or V643

Claims billed with diagnosis code V641, V642, or V643 or modifier 73 or 74 suspend for review of the medical documentation submitted with the claim. Providers must submit the operative report, the anesthesia report, and state why the operation was not completed.

Reimbursement to ASC and HASC facilities for canceled or incomplete surgeries because of patient complications is made according to the following criteria, based on the extent to which the anesthesia or surgery proceeded:

- Reimburse at 0 percent of ASC group payment schedule for a procedure that is terminated for nonmedical or medical reasons before the facility has expended substantial resources
- Reimburse at 33 percent of ASC group payment schedule up to the administration of anesthesia
- Reimburse at 67 percent of ASC group payment schedule after the administration of anesthesia but before incision
- Reimburse at 100 percent of ASC group payment schedule after incision

Surgeries canceled because of incomplete preoperative procedures are not reimbursed.

2.2.4 Cochlear Implants
A cochlear implant is a benefit of Texas Medicaid when medically indicated. ASC and HASC providers may be reimbursed for the implantation procedure using procedure code 69930, and for the cochlear implant devices using procedure code L8614.


2.2.5 Colorectal Cancer Screening
Procedure codes G0104, G0105, and G0106 (total or technical component) are a benefit of Texas Medicaid in the ASC or HASC setting.

Procedure codes G0104 and G0106 are limited to diagnosis codes V1272, V7650, V7651, V7652, or V700. Procedure code G0105 is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>5550</td>
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<tr>
<td>5563</td>
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<tr>
<td>V1006</td>
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Refer to: Subsection 6.3.11.3, “Colorectal Cancer Screening” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks).
2.2.6 Fluocinolone Acetonide
The fluocinolone acetonide (Retisert) intravitreal implant will be considered for reimbursement for outpatient hospitals and HASCs for clients 12 years of age or older with prior authorization. Procedure code J7311 is payable only with a posterior uveitis diagnosis (diagnosis code 36320) of more than 6 months in duration and only when the condition has been unresponsive to oral or systemic medication treatment. To request prior authorization, providers must submit requests to the Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Refer to: Forms, “Special Medical Prior Authorization (SMPA) Request Form” in this handbook.

2.2.7 Implantable Infusion Pumps
Procedure codes E0782 and E0783 are a benefit of Texas Medicaid if a medical necessity exists. Implantable infusion pumps may be medically necessary in the following circumstances:

- Intrathecal administration of anti-spasmodic drugs to treat chronic intractable spasticity
- Administration of opioid drugs for treatment of severe chronic intractable pain
- Administration of intrahepatic chemotherapy in colorectal cancer with liver metastases
- Administration of intra-arterial chemotherapy in head and neck cancers
Prior authorization requests for implantable infusion pumps must be submitted to the Special Medical Prior Authorization Department.


2.2.8 Neurostimulators
Neurostimulators are a benefit of Texas Medicaid when medically necessary. All procedures require prior authorization.

Refer to: Subsection 6.3.37, “Neurostimulators” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)

2.2.9 Prior Authorization
Some procedures require the performing provider to obtain prior authorization. When prior authorization is required, providers can mail or fax the request to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

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

2.4.1 Claims Information
Freestanding ASC claims must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Hospital-based ASCs file a UB-04 CMS-1450.

Claims must contain the billing provider’s complete name, address, and a provider identifier. When completing a UB-04 CMS-1450 or a CMS-1500 claim form, providers must include all required information on the claim; TMHP does not key any information from claim attachments. Providers must purchase UB-04 CMS-1450 and CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

To bill for nurse anesthetists’ services, an ASC must enroll as a nurse anesthetist group provider and indicate the CRNA performing provider identifier on claims for those services.

Refer to: Section 3, “Certified Registered Nurse Anesthetist (CRNA)” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for specific billing instructions for CRNA services.

Section 6, Claims Filing (Vol. 1, General Information).

Section 10, “Claim Form Examples” in this handbook.

2.4.2 Reimbursement
Reimbursement of ASC and HASC procedures is based on the Centers for Medicare & Medicaid Services (CMS)-approved Ambulatory Surgical Code Groupings (1 through 9 per CMS and Group 10 per HHSC) payment schedule. When multiple surgical procedures are performed on the same day, only the procedure with the highest surgical code grouping is reimbursed. A complete list of approved ASC and HASC procedure codes with the assigned payment group can be found on the TMHP website at www.tmhp.com. Click on Fee Schedules. This list can also be obtained by calling the TMHP Contact Center at 1-800-925-9126.

2.4.2.1 ASC and HASC Global Services
The ASC or HASC payment represents a global payment and includes room charges and supplies. Covered services provided are billed as one inclusive charge. All facility services provided in conjunction with the surgery (e.g., laboratory, radiology, anesthesia supplies, medical supplies) are considered part of the global payment and cannot be itemized or billed separately.

Routine X-ray and laboratory services directly related to the surgical procedure being performed are not reimbursed separately. All nonroutine laboratory and X-ray services provided with emergency conditions may be billed separately with documentation that the complicating condition arose after the initiation of the surgery.

No separate payment outside of the ASC or HASC reimbursement rate will be made for prosthetic devices. Medical and prosthetic devices such as implantable pumps and intraocular lenses may be supplied by the ASC or HASC and implanted, inserted, or otherwise applied during a covered surgical procedure.

Exception: Certain pieces of equipment, (e.g., cochlear implant and neurostimulator devices) may be reimbursed separately from the ASC or HASC global rate.

Physician and certified registered nurse anesthetist (CRNA) services performed in an ASC or HASC must be billed under the physician or CRNA provider identifier and are reimbursed separately.

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

Subsection 2.3.3.7, “Day Surgery” in Hospital Services Handbook (Vol. 2, Provider Handbooks) for information about hospital-based ambulatory surgical centers.
3. FEDERALLY QUALIFIED HEALTH CENTER

3.1 Enrollment

To enroll in Texas Medicaid, an FQHC must be receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or designated by the U.S. Department of Health and Human Services (HHS) to have met the requirements to receive this grant. FQHCs and their satellites are required to enroll in Medicare to be eligible for Medicaid enrollment. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver for the Medicare prerequisite at the time of initial enrollment of FQHC parents and satellites. FQHC look-alikes are not required to enroll in Medicare but may elect to do so to receive reimbursement for crossovers.

Refer to: Subsection 3.3.2.1, “Medicare-Medicaid Crossover Claims Pricing” in this handbook.

A copy of the Public Health Service’s Notice of Grant Award reflecting the project period and the current budget period must be submitted with the enrollment application. A current notice of grant award must be submitted to TMHP Provider Enrollment annually.

FQHCs are required to notify TMHP of all satellite centers that are affiliated with the parent FQHC and their actual physical addresses. All FQHC satellite centers billing Texas Medicaid for FQHC services must also be approved by the United States Department of Health and Human Services Health Resources and Services Administration (HRSA). For accounting purposes, centers may elect to enroll the HRSA-approved satellites using a Federally Qualified Satellite (FQS) provider identifier that ties back to the parent FQHC provider identifier and tax ID number (TIN). This procedure allows for the parent FQHC to have one provider agreement and one cost report that combines all costs from all approved satellites and the parent FQHC. If an approved satellite chooses to bill Texas Medicaid directly, the center must have a provider identifier separate from the parent FQHC and will be required to file a separate cost report.

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 Title 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 of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA will not be reimbursed for laboratory services.

FQHC providers can enroll as family planning providers.

Refer to: Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in Radiology, Laboratory and Physiological Lab Services Handbook (Vol. 2, Provider Handbooks).

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

3.1.1 Initial Cost Reporting

New FQHCs must file a projected cost report within 90 days of their designation as an FQHC to establish an initial payment rate. The cost report will contain the FQHC’s reasonable costs anticipated to be incurred during the FQHC’s initial fiscal year. The FQHC must file a cost report within 5 months of the
end of the FQHC's initial fiscal year. The cost settlement must be completed within 11 months of the receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases shall be calculated as provided herein.

FQHC providers are required to submit a copy of their Medicare-audited cost report for the provider’s fiscal year within 15 days of receipt from Medicare to:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

A new FQHC location established by an existing FQHC participating in Texas Medicaid will receive the same effective rate as the FQHC establishing the new location. An FQHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

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

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

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

The services listed in the tables below may be reimbursed to FQHCs using the National Provider Identifier (NPI):

<table>
<thead>
<tr>
<th>General Medical Services</th>
</tr>
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<tbody>
<tr>
<td>T1015</td>
</tr>
<tr>
<td>General medical services must be billed using one of the appropriate modifiers AH, AJ, AM, SA, TD, TE, TH, or U7.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Adult Preventative Care</th>
</tr>
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<tbody>
<tr>
<td>99385 99386 99387 99395 99396 99397</td>
</tr>
<tr>
<td>Adult preventative care must be billed with diagnosis code V700.</td>
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<tr>
<th>Case Management</th>
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<tbody>
<tr>
<td>G9012</td>
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<tr>
<td>Comprehensive visit must be billed using modifiers U2 and U5. Follow-up face-to-face visit must be billed using modifiers TS and U5. Follow-up telephone visit must be billed using modifier TS.</td>
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<thead>
<tr>
<th>Family Planning Services</th>
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<tbody>
<tr>
<td>99201 99202 99203 99204 99205 99211 99212 99213 99214 99215</td>
</tr>
<tr>
<td>J7300 J7302</td>
</tr>
<tr>
<td>Annual family planning examination must be billed with modifier FP.</td>
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<tr>
<th>Mental Health Services</th>
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<tbody>
<tr>
<td>90801 90802 90804 90805* 90806 90807* 90808 90809* 90810 90811*</td>
</tr>
<tr>
<td>90812 90813* 90814 90815* 90816 90817* 90818 90819* 90821 90822*</td>
</tr>
<tr>
<td>90823 90824* 90826 90827* 90828 90829* 90847 90853 90857 90865</td>
</tr>
</tbody>
</table>

* Procedures cannot be performed by Psychologist. Mental health services must be billed using one of the appropriate modifiers AH, AJ, AM, U1, or U2.
**Procedure codes D8210, D8220, and D8080 must be billed with Diagnostic Procedure Code (DPC) remarks codes for correct claims processing.**

Refer to: Subsection 6.3.5, “Modifiers” in Claims Filing (Vol. 1, General Information) for a definition of modifiers.

Section 5, “Texas Health Steps (THSteps) Dental” and Section 6, “THSteps Medical” in Children’s Services Handbook (Vol. 2, Provider Handbooks).


Medicaid coverage is limited to FQHC services that are covered by Texas Medicaid and are reasonable and medically necessary. When furnished to a client of the FQHC, medically necessary services include the following:

- Certified nurse midwife (CNM) services
- Clinical psychologist services
- Clinical social worker services; other mental health services
- Dental services
- Nurse practitioner (NP) services
- Other ambulatory services included in Medicaid such as family planning, Texas Health Steps (THSteps), and maternity service clinic (MSC)
- Physician assistant (PA) services
- Physician services
- Services and supplies necessary for services that would be covered otherwise, if furnished by a physician or a physician service
- Vision care services
- Visiting nurse services to a homebound individual, in the case of those FQHCs located in areas with a shortage of home health agencies

Types of FQHC visits are defined in 1 TAC §355.8261. A visit is a face-to-face encounter between an FQHC client and a physician, PA, NP, CNM, visiting nurse, qualified clinical psychologist, clinical social worker, other health-care professional for mental health services, dentist, dental hygienist, or optometrist. Encounters that take place on the same day at a single location with more than one health-care professional or multiple encounters with the same health-care professional constitute a single visit, except where one of the following conditions exists:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The FQHC client has a medical visit and an other health visit such as a qualified clinical psychologist, clinical social worker, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, or a THSteps medical screen.

All services provided that are incidental to the encounter, including developmental screening, must be included in the total charge for the encounter. They are not billable as a separate encounter.
If immunizations are given outside of a THSteps medical checkup, procedure codes given in the THSteps section of this manual should be used. These procedure codes are informational only, and are not payable.

To be reimbursed for Case Management for Children and Pregnant Women (CPW) an FQHC must be approved as a case management services provider by the Department of State Health Services (DSHS) Case Management Branch.

If a problem requiring evaluation and management (E/M) beyond the recommended services for a medical checkup is discovered, a separate E/M procedure code for an established patient, billed under the provider’s Medicaid provider identifier, may be reimbursed for the same date of service as a THSteps periodic medical checkup visit. For the acute care claim, an appropriate level Current Procedural Terminology (CPT) code for E/M of established patients should be selected with the diagnosis supporting this additional billing. The medical record must contain documentation that supports the medical necessity and the level of service of the E/M procedure code submitted for reimbursement.

An annual family planning examination is allowed once per fiscal year, per client, per provider. An FQHC may be reimbursed for up to 3 family planning encounters per client, per year, regardless of the reason for the encounter. The 3 encounters may include any combination of general family planning encounters, an annual family planning examination, or procedure code J7300 or J7302. Family planning services must be billed with the most appropriate evaluation and management procedure code and one of the following family planning diagnosis codes:

<table>
<thead>
<tr>
<th>Family Planning Diagnosis Codes</th>
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<tbody>
<tr>
<td>V2501</td>
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<tr>
<td>V2549</td>
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Diagnosis code V2652 is not covered by the Women’s Health Plan.

Only the annual family planning examination requires modifier FP. All other family planning visits do not. Claims filed incorrectly may be denied.


Gynecological services provided to Primary Care Case Management (PCCM) clients must be billed with modifier GY.

Laboratory and radiology services or the services of a licensed vocational nurse (LVN), registered nurse (RN), nutritionist, or dietitian are not considered an encounter, because they are incidental to an encounter with one of the previously-mentioned payable health-care professionals. Providers should continue to include the cost associated with these services on their cost report (they are allowable but do not constitute an encounter).

Per federal regulations, the provider cannot bill either Medicaid or the client for vaccines obtained from the Texas Vaccine for Children (TVFC) Program.

Refer to: Section 6, “THSteps Medical” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information.

3.2.1 Services to Migrant Farm Workers

FQHC out-of-state and border state providers that render services to PCCM clients 20 years of age or younger who are migrant farm workers or their children who are 20 years of age or younger do not need a referral from the client’s primary care provider. To be considered for reimbursement, providers must include modifier UC for each billed procedure code.
For PCCM clients who are 21 years of age or older, primary care provider referrals are still required on claims for services rendered by out-of-state and border-state providers.

3.2.2 After-Hours Care

After-hours care for FQHCs is defined as care provided on weekends, on federal holidays, or before 8 a.m. and after 5 p.m., Monday through Friday. After-hours care provided by FQHCs does not require a referral from the client’s primary care provider. If the encounter is for after-hours services to a PCCM client, modifier TU must be indicated on the claim in addition to other appropriate modifiers.

3.2.3 Prior Authorization

Prior authorization or authorization may be required for FQHC services. Refer to individual sections referenced on page 14.

3.3 Claims Filing and Reimbursement

3.3.1 Claims Information

All services provided that are incidental to the encounter should be included in the total charge for the encounter and are not billable as a separate encounter. For example, if an office visit was provided at a charge of $30 and a lab test for $15, the center would bill TMHP procedure code T1015 for $45 and would be reimbursed at the center’s encounter rate. All services (except for family planning, THSteps medical, THSteps dental, copayments, vision, mental health services, and case management for high-risk pregnant women and infants) provided during an encounter must be billed using procedure code T1015.

To obtain the encounter rate when they bill family planning services provided under Title XIX or WHP, FQHCs must use procedure code J7300 or J7302 or the most appropriate E/M procedure code with a family planning or WHP diagnosis code. These procedure codes must be submitted in conjunction with the most appropriate informational procedure codes for services that were rendered. Providers must use modifier FP only to bill the annual family planning examination.

FQHC services for clients who have only Medicaid must be submitted to TMHP in approved electronic format or on a UB-04 CMS-1450, CMS-1500, or Family Planning 2017 paper claim form. Providers may purchase UB-04 CMS-1450 or CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a UB-04 CMS-1450 or CMS-1500 paper 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.

Section 10, “Claim Form Examples” in this handbook.
Claims should be filed as follows:

<table>
<thead>
<tr>
<th>Services</th>
<th>Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>THSteps medical services</td>
<td>UB-04 CMS-1450 or CMS-1500 paper claim form or approved electronic format</td>
</tr>
<tr>
<td>Family planning claims filed by FQHC providers who have contracted with DSHS to provide Titles V, X, and XX</td>
<td>Family Planning 2017 Claim Form or approved electronic format</td>
</tr>
<tr>
<td>Family planning claims filed by FQHC providers not contracted with DSHS to provide Title V, X, or XX</td>
<td>UB-04 CMS-1450 or Family Planning 2017 paper claim form or approved electronic format</td>
</tr>
<tr>
<td>THSteps dental services</td>
<td>American Dental Association (ADA) Dental Claim Form or approved electronic format</td>
</tr>
<tr>
<td>CPW case management services</td>
<td>UB-04 CMS-1450 or CMS-1500 paper claim form or approved electronic format</td>
</tr>
</tbody>
</table>

When filing for a client who has Medicare and Medicaid coverage, providers must file on the same claim form that was filed with Medicare.

The ADA Dental Claim Form may be filed electronically or on paper. The form can be downloaded at www.ada.org/prof/resources/topics/claimform.asp.

All claims must be filed using the FQHC provider identifier.

Services provided by a health-care professional require one of the following modifiers with procedure code T1015, to designate the health-care professional providing the services: AH, AJ, AM, SA, TD, TE, or U7.

- If more than one health-care professional is seen during the encounter, the modifier should indicate the primary contact. The primary contact is defined as the health-care professional who spends the greatest amount of time with the client during that encounter.
- If the encounter is for antepartum care or postpartum care, the modifier TH must be indicated on the claim in addition to the appropriate modifier above.
- If the antepartum or postpartum care is provided by a CNM, the modifier SA must be indicated on the claim in addition to the appropriate modifier above.

Use modifier TD or TE for home health services provided in areas with a shortage of home health agencies.

### 3.3.2 Reimbursement

FQHCs are reimbursed provider-specific prospective payment system encounter rates in accordance with 1 TAC §355.8261. To be reimbursed for Case Management for Children and Pregnant Women (CPW) an FQHC must be approved as a case management services provider by the Department of State Health Services (DSHS) Case Management Branch. The FQHC must bill these services using its FQHC provider identifier and the appropriate procedure code for case management of CPW.

Refer to: “Prospective Payment Methodology” in 1 TAC §355.8261 for more information.

3.3.2.1 Medicare-Medicaid Crossover Claims Pricing

For FQHC Medicare-Medicaid crossover claims, Texas Medicaid pays the difference between the Medicaid encounter rate and any Medicare payment up to a maximum of the Medicaid encounter rate. If the Medicare payment is larger, no payment is made by Medicaid.

3.3.2.2 Provider Cost Reporting

FQHC providers are required to submit a copy of their Medicare-audited cost report for the provider’s fiscal year within 15 days of receipt from Medicare. Submit to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

3.4 Documentation Requirements

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

4. RENAL DIALYSIS FACILITY

4.1 Enrollment

To enroll in Texas Medicaid, a renal dialysis facility must be Medicare-certified in the state where it is located. Facilities must also adhere to the appropriate rules, licensing, and regulations of the state where they operate.

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

4.2 Services/Benefits, Limitations, and Prior Authorization

Renal dialysis is a benefit of Texas Medicaid for the following acute renal failure or end-stage renal disease (ESRD) diagnosis codes: 5845, 5846, 5847, 5848, 5849, 5855, and 5856.


Subsection 2.3.2.7, “Organ and Tissue Transplant Services” in Hospital Services Handbook (Vol. 2, Provider Handbooks) for information on organ transplant and facility services.

Dialysis treatments are a benefit of Texas Medicaid for clients in the home, office, inpatient hospital setting, outpatient hospital setting, or a renal dialysis facility. Outpatient dialysis is furnished on an outpatient basis at a renal dialysis center, facility, or home. Outpatient dialysis includes:

- Staff-assisted dialysis performed by the staff of the center or facility.
- Self-dialysis performed by a client with little or no professional assistance (the client must have completed an appropriate course of training).
- Home dialysis performed by an appropriately trained client (and the client’s caregiver) at home.
- Dialysis furnished in a facility on an outpatient basis at an approved renal dialysis facility.

The facility bills an amount that represents the charge for the facility’s service to the dialysis client. The facility’s charge must not include the charge for the physician’s routine supervision.
4.2.1 Renal Dialysis Facilities-Method I Composite Rate

The composite rate includes all necessary equipment, supplies, and services for the client receiving dialysis whether in the home or in a facility. Examples of services included in the composite rate include, but are not limited to:

- Cardiac monitoring—procedure code 93040 or 93041
- Catheter changes—procedure code 36000, 49420, or 49421
- Crash cart usage for cardiac arrest
- Declotting of shunt performed by facility staff (hemodialysis—procedure code 36593)
- Dialysate—procedure code A4720, A4722, A4723, A4724, A4725, A4726, or 4765
- Oxygen—procedure code E0424, E0431, E0434, E0439, E0441, E0442, E0443, or E0444
- Routine laboratory services for dialysis

  Note: When one of these laboratory services is required more frequently, renal dialysis facility providers should bill the appropriate procedure code with modifier 91 for separate reimbursement.

- Staff time to administer blood, separately billable drugs, and blood collection for laboratory—procedure codes 36430 or 36591
- Suture removal or dressing changes

- Certain drugs such as those to elevate or decrease blood pressure, antiarrythmics, blood thinners or expanders, antihistamines or antibiotics to treat infections or peritonitis are included in the composite rate. Examples include, but are not limited to:

  - Hydralazine—procedure code J0360
  - Diphenhydramine—procedure code J1200
  - Heparin—procedure code J1642 or J1644
  - Dopamine—procedure code J1265
  - Glucose
  - Propranolol—procedure code J1800
  - Insulin
  - Digoxin—procedure code J1160
  - Norepinephrine bitartrate
  - Mannitol—procedure code J2150
  - Procaine
  - Protamine—procedure code J2720
  - Saline—procedure code A4216 or A4217
  - Hydrocortisone sodium succinate—procedure code J1720
  - Verapamil
### 4.2.2 Method II Dealing Direct-Support Services

With Method II, the client selects and works with a single supplier to obtain supplies and equipment to dialyze at home. The selected supplier cannot be a dialysis facility, although the supplier must maintain a written agreement with a support dialysis facility to provide backup and support services. Method II support services are reimbursed under revenue codes 845 and 855.

Support services are reimbursed monthly under Method II are limited to clients 20 years of age or younger, and include, but are not limited to:

- Periodic monitoring of a client’s adaptation to home dialysis and performance of dialysis, including provisions for visits to the home or the facility.
- Visits by trained personnel for the client with a qualified social worker and a qualified dietitian, made in accordance with a plan prepared and periodically reviewed by a professional team which includes the physician.
- Individual unscheduled visits to a facility made on an as-needed basis; (e.g., assistance with difficult access situations).
- The same ESRD related laboratory tests covered under the composite rate.
- Providing, installing, repairing, testing, and maintaining home dialysis equipment, including appropriate water testing and treatment.
- Ordering of supplies on an ongoing basis.
- A record keeping system that assures continuity of care.
- Support services specifically applicable to chronic ambulatory peritoneal dialysis (CAPD) also include, but are not limited to:
  - Changing the connecting tube and administration set.
  - Monitoring the client’s performance of CAPD, assuring that it is done correctly, and reviewing proper techniques with the client or informing the client of modifications to apparatus or technique.
  - Documenting whether the client has or has had peritonitis that requires physician intervention or hospitalization (unless there is evidence of peritonitis, a culture for peritonitis is not necessary).
  - Inspecting the catheter site.

Routine laboratory services are included in the support services and are not reimbursed separately.

Equipment and supplies are:

- Reimbursed under Method II to only one provider per month who must agree to bill once per month for only 1 month’s quantity per claim.
- Limited to clients 20 years of age or younger.
- Reimbursed separately up to the total monthly allowable as determined by HHSC.

The following equipment, supply, and services procedure codes are benefits of Texas Medicaid:

<table>
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<tr>
<th>Procedure Codes</th>
<th>36000</th>
<th>36430</th>
<th>36591</th>
<th>36593</th>
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</table>

*Procedure codes that are benefits of Texas Medicaid for DME suppliers billing under Method II Reimbursement-Dealing Direct.*
A Medicaid client may receive CAPD and continuous cycle peritoneal dialysis (CCPD) support services furnished by the facility on a monthly basis. Charges for support services in excess of this frequency must include documentation of medical necessity.

Clients may have a 1 month reserve of supplies available for use. Renal dialysis services beyond these limitations may be considered for clients birth through 20 years of age through the Comprehensive Care Program (CCP) with prior authorization.

### 4.2.3 Facility Revenue Codes

The following services are a benefit for renal dialysis centers billing under reimbursement methodology I composite rate or II dealing direct. Method II is limited to clients 20 years of age or younger.

<table>
<thead>
<tr>
<th>Service</th>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance</td>
<td>821</td>
<td>Hemodialysis (outpatient/home)--composite or other rate</td>
</tr>
<tr>
<td></td>
<td>831</td>
<td>Peritoneal Dialysis (outpatient/home)--composite or other rate</td>
</tr>
<tr>
<td></td>
<td>841</td>
<td>CAPD (outpatient/home)--composite or other rate</td>
</tr>
<tr>
<td></td>
<td>851</td>
<td>CCPD (outpatient/home)--composite or other rate</td>
</tr>
<tr>
<td>Training</td>
<td>829</td>
<td>Hemodialysis (outpatient/home)--other</td>
</tr>
<tr>
<td></td>
<td>839</td>
<td>Peritoneal Dialysis (outpatient/home)--other</td>
</tr>
<tr>
<td></td>
<td>849</td>
<td>CAPD (outpatient/home)--other</td>
</tr>
<tr>
<td></td>
<td>859</td>
<td>CCPD (outpatient/home)--other</td>
</tr>
<tr>
<td>Support</td>
<td>845</td>
<td>CAPD (outpatient/home)--support services</td>
</tr>
<tr>
<td></td>
<td>855</td>
<td>CCPD (outpatient/home)--support services</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>881</td>
<td>Miscellaneous dialysis--ultrafiltration</td>
</tr>
</tbody>
</table>

* Procedure codes that are benefits of Texas Medicaid for DME suppliers billing under Method II Reimbursement-Dealing Direct.

### 4.2.4 Training for Hemodialysis, IPD, CCPD, and CAPD

Most self-dialysis training for hemodialysis, intermittent peritoneal dialysis (IPD), CCPD, and CAPD is provided in an outpatient setting. Dialysis training provided in an inpatient setting will be reimbursed at the same rate as the facility’s outpatient training rate.

Reimbursement for hemodialysis, IPD, CCPD, and CAPD training services and supplies provided by the dialysis facility include personnel services, parenteral items routinely used in dialysis, training manuals and materials, and routine dialysis laboratory tests.
No frequency limitation is applied to routine laboratory tests during the training period because these tests commonly are given during each day of training. Nonroutine laboratory tests performed during the training period may be reimbursed when documentation of medical necessity is submitted with the claim.

It may be necessary to supplement the patient’s dialysis during CAPD training with intermittent peritoneal dialysis or hemodialysis because the client has not mastered the CAPD technique.

Training is limited to once per day. The composite rate will be denied as part of dialysis training when billed for the same date of service.

4.2.5 Maintenance Hemodialysis
The facility composite rate applies when a chronic renal dialysis client receives hemodialysis in an approved renal dialysis facility. Reimbursement is based on the facility’s per-treatment composite rate, as calculated by Medicare. Services included in the facility’s charge are routine laboratory tests, personnel services, equipment, supplies, and other services associated with the treatment.

For hospitals to be reimbursed for maintenance hemodialysis, they must be enrolled as an approved dialysis facility with the appropriate provider identifier. When a client is admitted for hospitalization for no reason other than to receive maintenance renal dialysis, the dialysis services are considered outpatient services and are covered if the hospital has been designated as a CMS certified renal dialysis center.

4.2.6 Maintenance IPD
Maintenance IPD is usually performed in sessions of 10 to 12 hours duration, 3 times per week. It may also be performed in fewer sessions that are longer in duration. If more than three sessions occur in 1 week, the provider must supply documentation of medical necessity with the claim.

4.2.7 Maintenance CAPD and CCPD
Support services for maintenance furnished to clients receiving CAPD or CCPD in the home may be reimbursed to dialysis facilities. Home dialysis support services must be furnished by the facility in either the home or the facility. CAPD and CCPD support services are limited to once per day.

4.2.8 Laboratory and Radiology Services
All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

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

Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in Radiology, Laboratory and Physiological Lab Services Handbook (Vol. 2, Provider Handbooks).

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

4.2.8.1 In-Facility Dialysis—Routine Laboratory
Laboratory testing may be obtained and processed in the renal dialysis facility or by an outside laboratory. Charges for routine laboratory tests performed according to the established frequencies in the following tables are included in the facility’s composite rate billed to Texas Medicaid regardless of where tests were processed. If the routine laboratory testing is processed by an outside laboratory, the outside laboratory will bill the renal dialysis facility. The renal dialysis facility will then bill Texas Medicaid unless the test results are inconclusive.

If additional in-facility laboratory testing is medically necessary beyond the routine frequencies identified below, providers must bill with modifier 91 to indicate the billed laboratory procedure is medically necessary. The billing provider must maintain documentation supporting this medical necessity in the client’s medical record.
Modifier 91 is used to indicate that a test was performed more than once on the same day for the same client only when it is necessary to obtain multiple results in the course of the treatment. This modifier may not be used to indicate any of the following:

- When tests are re-run to confirm initial results
- Testing problems with specimens or equipment
- When a normal one-time, reportable result is all that is required
- When there are standard Healthcare Common Procedure Coding System (HCPCS) codes available that describe the series of results (e.g., glucose tolerance tests, evocative/suppression testing, etc.).

Modifier 91 may only be used for laboratory tests paid under the clinical diagnostic laboratory fee schedule.

### Per Dialysis

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
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<td>85014</td>
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### Per Week

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>82565</td>
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### Per Month

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>82040</td>
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<tr>
<td>85025</td>
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</table>

The routine tests listed in the tables above are frequently performed as an automated battery of tests such as the sequential multi-channel analysis with computer (SMAC)-12 (chemistry panels). These tests are considered routine and are included in the charge for dialysis, unless there is an additional diagnosis to document medical necessity for performing the tests in excess of the recommended frequencies.

Refer to: Subsection 2.2.2, “Laboratory Paneling” in Radiology, Laboratory and Physiological Lab Services Handbook (Vol. 2, Provider Handbooks) for more information about laboratory paneling procedures.

### 4.2.8.2 In-Facility Dialysis—Nonroutine Laboratory

The following procedure codes are considered necessary, nonroutine tests. They must be billed separately from the dialysis charge when performed in the renal dialysis facility or by an outside laboratory that bills the facility for laboratory services. All nonroutine laboratory and radiology tests beyond the recommended frequencies below must be medically necessary.

If additional in-facility laboratory testing is medically necessary beyond the nonroutine frequencies identified below, providers must bill with modifier 91 to indicate the billed laboratory procedure is medically necessary. The billing provider must maintain documentation supporting this medical necessity in the client's medical record.
## Once a Month

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## Every 3 Months

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## Every 6 Months

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## Annually

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<tr>
<td>78300 78305 78306</td>
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</table>

A handling fee (procedure code 99001) for nonroutine laboratory services may be billed to Texas Medicaid only if the specimen is obtained by venipuncture or catheterization and sent to an outside lab. The claim form must document that the handling fee is for nonroutine laboratory services.

### 4.2.8.3 CAPD

The following laboratory tests are routine for home maintenance CAPD clients when performed according to the indicated frequency. These laboratory tests may be reimbursed separately when the client is dialyzing in the home and is not undergoing IPD or hemodialysis in the facility. The provider must indicate the client’s diagnosis and the type of dialysis on the claim form. Tests in excess of this frequency or tests not listed in the tables require documentation of medical necessity for payment to be made.

## Every Month

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>82040 82310 82374 82565 83615 83735 84075 84100 84132 84155</td>
</tr>
<tr>
<td>84295 84450 84520 85018</td>
</tr>
</tbody>
</table>

## Every 3 Months

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>85004 85007 85008 85014 85027 85041</td>
</tr>
</tbody>
</table>

## Every 6 Months

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>71010 71020 78300 78305 78306 80069 81050 95900</td>
</tr>
</tbody>
</table>
4.2.8.4 Hematopoietic Injections

Medicaid reimbursement is allowed for hematopoietic injections administered to clients with the following indications:

- Anemia associated with chronic renal failure, including clients on dialysis ESRD and clients not on dialysis
- Anemia related to therapy with zidovudine (AZT) in HIV-infected clients
- Anemia due to the effects of concomitantly administered chemotherapy in clients with non-myeloid malignancies
- Anemia of prematurity
- Clients scheduled to undergo elective non-cardiac, non-vascular surgery to decrease need for allogenic blood transfusion
- Treatment of anemia in clients with non-myeloid malignancies where anemia is due to the effect of chemotherapy

Refer to: Subsection 6.3.32.15, “Hematopoietic Injections” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for more information about benefit and limitation criteria.

4.2.8.5 Blood Transfusions

Whole blood transfusions may be reimbursed separately to dialysis facilities when medically indicated for a Medicaid eligible client. The administration of the blood transfusion is not reimbursed separately to dialysis facilities but may be reimbursed to the medical professional administering the blood product.

4.2.9 Prior Authorization

Prior authorization is not required for renal dialysis facility services but may be required for certain home dialysis equipment.

4.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including renal dialysis services. Renal dialysis services are subject to retrospective review and recoupment if documentation does not support the service billed.

4.4 Claims Filing and Reimbursement

4.4.1 Claims Information

Renal dialysis facility services must be submitted to Texas Medicaid & Healthcare Partnership (TMHP) in an approved electronic claims format or on a UB-04 CMS-1450 claim form. Providers may purchase UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply them.

When completing a UB-04 CMS-1450 claim form, all required information must be included on the claim, as information is not keyed from 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 6.6, “UB-04 CMS-1450 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.
Reminder: The original onset date must be included on the claim form to prevent claim denial. The original onset date must be the same date entered on Form CMS-2728 sent to the Social Security office.

4.4.2 Reimbursement
Renal dialysis facilities are reimbursed according to composite rates, which are based on the Centers for Medicare & Medicaid Services (CMS)-specified calculations and the Texas Medicaid Reimbursement Methodology (TMRM). Texas Medicaid may reimburse for dialysis services through either Method I or Method II as defined by CMS.

The hemodialysis, intermittent peritoneal dialysis (IPD), continuous ambulatory peritoneal dialysis (CAPD) and continuous cycling peritoneal dialysis (CCPD) laboratory and radiology services and the physician supervision of dialysis clients limitations pertain to both Method I and Method II reimbursement.

4.5 Medicare and Medicaid
Medicaid coverage of a renal dialysis client who may be eligible for Medicare coverage begins with the original onset date of the dialysis treatments and may continue for a period of 3 months. During this period, Medicare eligibility is reviewed through the Health and Human Services Commission (HHSC). If HHSC determines that the client is Medicare-eligible, Medicaid coverage begins with the original onset date and continues until Medicare coverage begins.

If HHSC determines that the client is not eligible for Medicare, Medicaid coverage of eligible clients begins with the original onset date and continues as long as the dialysis treatments are medically necessary and the client is eligible for Medicaid. The date of onset is the date of the first dialysis treatment and does not change even if the client sees another provider.

Medicare eligibility usually begins after a 3-month waiting period has been served. Medicare eligibility begins before the waiting period has expired if the individual receives a transplant or participates in a self-dialysis training program during the waiting period.

Medicaid may pay Medicare deductibles and coinsurance for clients who are eligible.

5. RURAL HEALTH CLINIC

5.1 Enrollment
To enroll in Texas Medicaid and qualify for participation as a Title XIX RHC, RHCs must be enrolled in Medicare. A 9-digit provider identifier is issued to the RHC after a certification letter from Medicare is received, stating that the clinic qualifies for Medicaid participation. An RHC can also apply for enrollment as a family planning agency.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA are not reimbursed for laboratory services.

5.1.1 Initial Cost Reporting
New RHCs must file a projected cost report within 90 days of their designation as an RHC to establish an initial payment rate. The cost report will contain the RHC’s reasonable costs anticipated to be incurred during the RHC’s initial fiscal year. The RHC must file a cost report within 5 months of the end of the RHC’s initial fiscal year. The cost settlement must be completed within 11 months of the receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases shall be calculated as provided herein. A new RHC location established by an
existing RHC participating in Texas Medicaid will receive the same effective rate as the RHC establishing the new location. An RHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

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

Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in Radiology, Laboratory and Physiological Lab Services Handbook (Vol. 2, Provider Handbooks).

5.2 Services/Benefits, Limitations, and Prior Authorization

The services listed in the table below may be reimbursed to RHC providers.

<table>
<thead>
<tr>
<th>General Medical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1015</td>
</tr>
<tr>
<td>General medical services must be billed using one of the appropriate modifiers AJ, AH, AM, SA, TE, TH, or U7. Adult preventative care must be billed with diagnosis code V700.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THSteps Medical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381 99382 99383 99384 99385 99391 99392 99393 99394 99395</td>
</tr>
<tr>
<td>THSteps medical services must be billed using modifier EP and one of the following modifiers AM, SA, or U7.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Planning Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 99202 99203* 99204* 99205 99211 99212 99213* 99214* 99215</td>
</tr>
<tr>
<td>J7300* J7302*</td>
</tr>
<tr>
<td>Family planning services must be billed with modifier AJ, AM, SA, or U7 and place of service 72. Annual family planning services must be billed with modifier FP.</td>
</tr>
</tbody>
</table>
*Title V and XX may only submit these procedure codes for family planning services. |

<table>
<thead>
<tr>
<th>Copayments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP001 CP002 CP003 CP004 CP005 CP006 CP007 CP008</td>
</tr>
</tbody>
</table>

Family planning services must be billed with the most appropriate E/M procedure code and one of the following family planning diagnosis codes:

<table>
<thead>
<tr>
<th>E/M Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2502 V2504 V2509 V251 V252 V2540 V2541 V2542 V2543 V2549</td>
</tr>
<tr>
<td>V255 V258 V259 V265 V2652</td>
</tr>
</tbody>
</table>

Diagnosis V2652 is not covered by the Women’s Health Plan.

If a problem requiring E/M beyond the recommended services for a medical checkup is discovered, a separate E/M procedure code for an established patient, billed under the provider’s RHC provider identifier, may be reimbursed for the same date of service as a THSteps periodic medical checkup visit. For the acute care claim, an appropriate level Current Procedural Terminology (CPT) code for E/M of established patients should be selected with the diagnosis supporting this additional billing. The medical record must contain documentation that supports the medical necessity and the level of service of the E/M procedure code submitted for reimbursement.
Refer to: Subsection 6.3.5, ”Modifiers” in Section 6, “Claims Filing”, for a definition of modifiers.


Section 3, “Medicaid Title XIX family planning services” in Gynecological and Reproductive Health, Obstetrics, and Family Planning Services Handbook (Vol. 2, Provider Handbooks).


5.2.1 Freestanding and Hospital-Based RHC Services

An RHC must be located in an area designated by the federal government as a health-care shortage area. The following services are benefits of Texas Medicaid when provided in an RHC:

- Physician services
- Services and supplies furnished as incidental to physician services
- Services provided by an NP, a CNM, a clinical social worker, or a PA’s services
- Services and supplies furnished as incidental to the NP’s or PA’s services
- Visiting nurse services on a part-time or intermittent basis to homebound clients in areas determined to have a shortage of home health agencies (A homebound client is someone who is permanently or temporarily confined to his place of residence, not including a hospital or skilled nursing facility, because of a medical condition.)

When an RHC bills for visiting nurse services, the written plan of treatment to be used for the visiting nurse must be developed by the RHC supervising physician. It must be approved and ordered by the client’s treating physician if different from the supervising physician. The plan of treatment must be reviewed and approved by the supervising physician of the clinic at least every 60 days.

Gynecological services provided to PCCM clients must be billed with modifier GY.

A visit is a face-to-face encounter between an RHC client and a physician, PA, NP, CNM, visiting nurse, or clinical NP. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one or the other of the following conditions exists:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The RHC client has a medical visit and an other health visit.

An other health visit includes, but is not limited to, a face-to-face encounter between an RHC client and a clinical social worker.

For freestanding RHCs, all laboratory services provided in the RHC’s laboratory are included in the encounter. This includes the basic laboratory tests as well as any other laboratory tests provided in the RHC laboratory. Consequently, there is no separate billing for laboratory services. However, if the RHC laboratory becomes a certified Medicare laboratory with its own supplier number, and enrolls in Medicaid as an independent laboratory, all laboratory tests (except the basic laboratory tests) performed
for RHC and non-RHC clients can be billed to Medicaid. The claim should be filed under their independent laboratory Medicaid provider identifier and using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes.

### 5.2.1.1 Freestanding Rural Health Clinic Services

The services listed below cannot be reimbursed to freestanding RHCs using only the RHC provider identifier. Use of the RHC provider identifier for billing these services causes claims to deny. Services in any of these three categories must be billed using the RHC provider identifier and the appropriate benefit code:

- THSteps medical checkups, which includes immunizations
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)

These services must be billed with an AM, SA, or U7 modifier.

Physician supplies are not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits. Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be billed using the individual or group physician provider identifier.

**Exception:** If later in the same day the client suffers an additional illness or injury requiring diagnosis or treatment, the clinic may bill for a second visit.

Freestanding RHCs bill an all-inclusive encounter for services provided. All services provided that are incidental to the encounter, including developmental screening, must be included in the total charge for the encounter. They are not billable as a separate encounter.

If immunizations are given outside of a THSteps medical checkup, procedure codes given in the THSteps section of this manual should be identified on the claim. These procedure codes are informational only, and are not payable.

All services provided during a freestanding RHC encounter must be billed using procedure code T1015. The total billed amount should be the combined charges for all services provided during that encounter.

One of the following modifiers must be reported with procedure code 1-T1015 to designate the healthcare professional providing the services: AH, AJ, AM, SA, TD, TE, or U7. If the encounter is for antepartum or postpartum care, use modifier TH in addition to the modifier required to designate the healthcare professional providing the service.

**Reminder:** The primary initial contact is defined as “the healthcare professional who spends the greatest amount of time with the client during that encounter.”

If more than one healthcare professional is seen during the encounter, the modifier (if appropriate) must indicate the primary contact. For example, if an NP or a PA performs an antepartum exam, modifiers SA or U7, and TH, must be entered. A maximum of two modifiers may be reported with each encounter.

### 5.2.1.2 Hospital-Based Rural Health Clinic Services

Hospital-based RHCs must use the encounter code T1015. A hospital-based RHC is paid based on an all-inclusive encounter rate. One of the following modifiers must be billed for general medical services: AH, AJ, AM, SA, TD, TE, or U7.
The services listed below must be billed using the RHC provider identifier and the appropriate benefit code:

- THSteps medical checkups
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)
- Immunizations provided in hospital-based RHCs

These services must be billed with an AM, SA, or U7 modifier if performed in an RHC setting. Claims are paid under the Prospective Payment System (PPS) reimbursement methodology. When billing on the CMS-1500 paper claim form, use the appropriate national POS (72) for an RHC setting.

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be billed using the individual or group physician provider identifier. Hospital-based RHCs should bill pneumococcal and influenza vaccines as non-RHC services, under their hospital provider identifier.

5.2.1.3 After-Hours Care
After-hours care for RHCs is defined as care provided on weekends, federal holidays, or before 8 a.m. and after 5 p.m. Monday through Friday. After-hours care provided by RHCs do not require a referral from the client’s primary care provider. RHCs that provide after-hours services to PCCM clients must submit claims with modifier TU.

5.2.2 Prior Authorization
Prior authorization or authorization is not required for RHC services.

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

5.3.1 Record Retention
Freestanding RHCs must retain their records for a minimum of six years. Hospital-based RHCs must retain their records for a minimum of ten years.

5.4 Claims Filing and Reimbursement
5.4.1 Claims Information
General services and copayments are billed using the RHC’s National Provider Identifier (NPI). For all other services, providers must bill using their NPI and the appropriate benefit code.

Place of service 72 must be used on all claims when billing for services other than general medical.

Freestanding and hospital-based RHC services must be submitted to TMHP in an approved electronic format or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper 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 6.6, “UB-04 CMS-1450 Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

5.4.2 Reimbursement
Freestanding and hospital-based RHCs are reimbursed provider-specific per visit rates calculated in accordance with 1 TAC §355.8101.

5.4.2.1 Cost Report Submission
All RHCs are required to submit a copy of their Medicare audited cost report for the fiscal year ending on or after January 1 within 15 days of receipt from Medicare. Submit to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

6. TUBERCULOSIS CLINICS

TB clinics must be enrolled in Texas Medicaid and provide services in accordance with Title 1, Texas Administrative Code (TAC), §354.1371.

6.1 Enrollment
To enroll in Texas Medicaid, a TB clinic must be either:

- A public entity operating under an HHSC tax identification number (TB regional clinic)
- A public entity operating under a non-HHSC tax identification number (city/county/local clinic)
- A nonhospital-based entity for private providers

Providers of TB-related clinic services must complete a provider application from the TB Services Branch within DSHS. Per Texas DSHS policy, TB clinics must develop and operate under a set of written policies and procedures that specify the criteria for licensed and non-licensed staff to provide services. The policies and procedures must include the following:

- The personnel file requirements for staff who provide directly observed therapy (DOT).
- The training and supervision that are required for outreach workers to be considered qualified to perform the assigned services.
- The written delegation protocol for services that are not performed by a physician, APRN, or PA.
- The documentation that is required for all client encounters.

Upon written notice of approval by TB Services Branch, Medicaid enrollment applications from TMHP Provider Enrollment are sent to HHSC-approved providers of TB-related clinic services.
TMHP is responsible for issuing a group or individual a 9-digit provider identifier. Providers that list additional (satellite) clinics in the TB Services Branch provider application will receive 9-digit performing provider identifiers for each off-site clinic. TB off-site clinics operating under the jurisdiction of the applying provider must use the assigned group provider identifier and their 9-digit performing provider identifier.

Enrollment as a Medicaid provider is not complete until the TMHP enrollment packet has been finalized and a 9-digit provider identifier number is issued to the provider.

The effective date for participation is the date an approved provider application with the TB Services Branch is established.

To receive a TB Services Branch provider application form or provider supplement, send a request to the following address:

Texas Department of State Health Services
TB/HIV/STD Unit
Tuberculosis Services Branch
Mail Code 1939
1100 West 49th Street
PO Box 149347
Austin, TX 78714-9347

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

6.1.1 Managed Care Program Enrollment

TB clinics do not need to enroll with the Medicaid managed care health plans. All services provided by TB clinics are submitted to TMHP for all Medicaid clients, including Medicaid managed care clients.

Refer to: Subsection 8.1, “Medicaid Managed Care” in Section 8, “Managed Care” (Vol. 1, General Information).

6.2 Services/Benefits, Limitations and Prior Authorization

The level of service provided varies depending on whether the services are delivered by a nonphysician or physician and if medications are prescribed.

6.2.1 TB-Related Clinic Services and Procedure Codes

Providers may be required to demonstrate the ability to provide the full scope of services and documentation of service delivery methodology. The services in the following sections are covered for reimbursement.

The following services may be performed by a physician, advanced practice registered nurse (APRN), or PA in the TB clinic:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
</tbody>
</table>

A physician’s presence may not be required to perform procedure code 99211, however, the physician must provide direct supervision by being present in the clinic and immediately available to furnish assistance and direction at the time service is provided.

One physician E/M service (listed in the table above) may be reimbursed per day, per client. Throughout the course of treatment, an examination must be performed every 90 days, or subsequent DOT will be denied.
Clients with latent TB infection, including those in a high-risk group (children 4 years of age or younger, those who are immunocompromised, and clients who are HIV positive), and those with active TB disease, must be seen by a physician every 90 days throughout the course of treatment.

A physician must evaluate each client with active or latent TB disease prior to discharge from TB treatment.

6.2.2 Initial Examination and Procedure Codes

Before TB treatment can be initiated, an initial screening, an RN, LPN, or LVN or a new patient physician E/M visit, must be performed. If the treatment is initiated by a nursing screening, a new patient physician E/M visit must be completed within 90 days, or subsequent reimbursement for DOT (procedure code H0033) will be denied.

The initial TB program screening (procedure code T1023) is a benefit when the screening is performed by an RN, LPN, or LVN in the clinic. The initial screen includes, but is not limited to, the following:

- Brief mental and physical assessment
- Exposure history
- Referral for lab or e-ray per protocol
- Referral for social or other medical services
- Other assessment

An initial screening performed by an RN, LPN, or LVN may be reimbursed prior to the client being seen by a physician and is limited to once per 12 months. Procedure code T1023 is limited to one per day and is denied if performed on the same date as a physician E/M visit.

A new client examination (procedure code 99201, 99202, 99203, 99204, or 99205) is limited to new clients who have not received services in the same TB clinic for a period of 3 years (36 calendar months.)

6.2.3 DOT/DOPT Examination

Throughout the course of treatment, an examination must be performed by a physician every 90 days, or subsequent DOT is denied.

DOT (procedure code H0033) is not a benefit when provided on the same date of service by any provider as the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
<tr>
<td>T1002</td>
</tr>
</tbody>
</table>

One of the following procedure codes must be billed by any provider within 90 days immediately preceding the date DOT is performed.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
</tbody>
</table>

Procedure code H0033 is limited to 1 per day, with a maximum of 5 per week, per client, throughout the course of treatment.
6.2.4 Ancillary Services

The following ancillary TB services are a benefit of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>71010</td>
</tr>
<tr>
<td>89220</td>
</tr>
<tr>
<td>J1956</td>
</tr>
</tbody>
</table>

*Must be billed with QW modifier

Certain injectable TB medications (procedure codes J2020, J2280, and J3000) also have an oral formulation and must be billed with the CK modifier to indicate that the oral formulation is not appropriate for this client.

All drugs for which Medicaid is billed must have been purchased by the TB clinic. In the event that the clinic received the drug at no cost through DSHS or another source, it cannot be billed to Texas Medicaid. All medication claims are subject to retrospective review.

Handling or conveyance of a specimen from the patient in the clinic to a laboratory (procedure code 99001) must be billed on the same date of service as one of the following procedure codes by the same provider:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
<tr>
<td>T1002</td>
</tr>
</tbody>
</table>

6.2.5 Prior Authorization

Prior authorization is not required for TB-related services.

6.3 Documentation Requirements

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

6.4 Provider Responsibilities

If approved to bill as a TB clinic under Texas Medicaid, the provider must adhere to the following requirements:

- Be a facility that is not an administrative, organizational, or financial part of a hospital, but is organized and operated to provide medical care to outpatients.
- Comply with all applicable federal, state, and local laws and regulations.
- Employ or have a contract or formal arrangement with a licensed physician (doctor of medicine [M.D.] or doctor of osteopathy [D.O.]) who is responsible for providing medical direction and supervision over all services provided to the clinic’s clients. To meet this requirement, a physician must see the client at least once, prescribe the type of care provided and, if the services are not limited by the prescription, periodically review the need for continued care.
- Adhere to the guidelines issued by HHSC, under the authority of the Texas Health and Safety Code, and ensure that services are consistent with the recommendations of the American Thoracic Society and the Centers for Disease Control and Prevention (CDC). For more information, visit the website at www.cdc.gov/tb/pubs/mmwr/maj_guide.htm.
• Ensure that services provided to each client are commensurate with the client’s medical needs based on the client’s assessment/evaluation, diagnostic studies, plan of care, and physician direction. These services must be documented in the client’s medical records.

• Be enrolled and approved for participation in Texas Medicaid.

• Sign a written provider agreement with HHSC or its designee. By signing the agreement, the provider of TB-related clinic services agrees to comply with the terms of the agreement and all requirements of Texas Medicaid including regulations, rules, handbooks, standards, and guidelines published by HHSC or its designee.

• Bill for services covered by Texas Medicaid in the manner and format prescribed by HHSC or its designee.

• Be organized and operated to provide TB-related services, which include, but are not limited to, the covered services as indicated in subsection 6.2, “Services/Benefits, Limitations and Prior Authorization” in this handbook.

• Not provide services within a skilled nursing facility (SNF), intermediate care facility (ICF), or intermediate care facility for persons with mental retardation (ICF-MR).

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

6.5 Claims Filing and Reimbursement

6.5.1 Claims Information

Procedure codes T1002 and T1003 must be billed as follows:
• Minutes of nursing services can only be billed per calendar day. Minutes of nursing services cannot accumulate over multiple days.

• If the total number of minutes of nursing services per procedure code is less than 8 minutes for a calendar day, then no unit of service can be billed for that day.

• If more than one unit of services is billed, each unit except the last must be for the complete 15 minutes. The last unit must be no less than 8 minutes of nursing services.

• Time spent in contact investigations is not reimbursable.

Certain injectable TB medications (procedure codes J2020, J2280, and J3000) which also have an oral formulation must be billed with the KX modifier to indicate that the oral formulation is not appropriate for the client.

Any drugs for which Medicaid is billed must have been purchased by the TB clinic. In the event that the clinic receives the drugs at no cost through DSHS or another source, the drug cannot be billed to Texas Medicaid.

All TB-related clinic services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form from the vendor of their choice. TMHP does not supply them. When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

NPI is required for all claims. In addition, for paper claims the TPI is required for the billing and performing provider only. NPI-only is required for all other fields. TB-related clinic services must use benefit code TB1 on all claims and authorization requests. All other providers must use benefit code CSN on all claims and authorization requests.
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 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.

6.5.2 Reimbursement
The Medicaid reimbursement rates for TB clinics are calculated in accordance with 1 TAC §355.8341. Chest X-rays are payable in addition to the encounter rate for TB clinic services because of the large variations in client needs and frequency of X-rays. X-ray services are reimbursed in accordance with 1 TAC §§355.8341 and 355.8081 and are listed in the current physician fee schedule on the TMHP website at www.tmhp.com.

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 F (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Ambulatory Surgical Center Claim Form Example</td>
<td>Form OP.2, Section 10 of this handbook</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
</tr>
<tr>
<td>CMS-1500 Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>2006 American Dental Association (ADA) Dental Claim Filing Instructions</td>
<td>Subsection 6.7 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Federally Qualified Health Center Report (Newborn Child or Children)</td>
<td>Form OP.1, Section 9 of this handbook</td>
</tr>
<tr>
<td>FQHC Encounter (T1015) Claim Form Example</td>
<td>Form OP.3, Section 10 of this handbook</td>
</tr>
<tr>
<td>FQHC Follow-Up Claim Form Example</td>
<td>Form OP.4, Section 10 of this handbook</td>
</tr>
<tr>
<td>Renal Dialysis Facility CAPD Training</td>
<td>Form OP.7, Section 10 of this handbook</td>
</tr>
<tr>
<td>Renal Dialysis Facility CAPD/CCPD</td>
<td>Form OP.8, Section 10 of this handbook</td>
</tr>
<tr>
<td>Rural Health Clinic Freestanding Claim Form Example</td>
<td>Form OP.10, Section 10 of this handbook</td>
</tr>
<tr>
<td>Rural Health Clinic Hospital-Based Claim Form Example</td>
<td>Form OP.12, Section 10 of this handbook</td>
</tr>
<tr>
<td>State and Federal Offices Communication Guide</td>
<td>Appendix A (Vol. 1, General Information)</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>Tuberculosis (TB) Claim Form Example</td>
<td>Form OP.13, Section 10 of this handbook</td>
</tr>
<tr>
<td>Tuberculosis Screening and Education Tool</td>
<td>Form A.27, Children’s Services Handbook (Vol. 2, Provider Handbooks)</td>
</tr>
<tr>
<td>UB-04 CMS-1450 Claim Filing Instructions</td>
<td>Subsection 6.6 (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>
8. CONTACT TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

9. FORMS
### Federally Qualified Health Center Report (Newborn Child or Children) (Form 7484)

**MAIL FORM TO:**

Texas Health and Human Services Commission  
Data Integrity 952-X  
PO Box 149030  
Austin, TX 78714-9030

**Date Rec’d in Data Integrity**

**PURPOSE:** This form is to be used by FEDERALLY QUALIFIED HEALTH CENTERS ONLY to report the birth of a child of a mother currently eligible under the Medicaid program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future medicaid claims payments. If the child’s FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

**ACTION:** To avoid delay in your receiving notice of the Medicaid client number of the newborn child, please complete this document and submit it to the HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child’s Medicaid claim.

To avoid delay in processing the child’s Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s Name (Last, First, MI)</td>
<td></td>
</tr>
<tr>
<td>Admission Date (mm/dd/yy)</td>
<td></td>
</tr>
<tr>
<td>Mother’s Medicaid Recipient No.</td>
<td></td>
</tr>
<tr>
<td>Mother’s Mailing Address--Street</td>
<td></td>
</tr>
<tr>
<td>Mother’s D.O.B. (mm/dd/yy)</td>
<td></td>
</tr>
<tr>
<td>Mother’s Medical Record No.</td>
<td></td>
</tr>
<tr>
<td>City, State, ZIP</td>
<td></td>
</tr>
<tr>
<td>Child’s (Last, First, MI)</td>
<td></td>
</tr>
<tr>
<td>Sex (M/F)</td>
<td></td>
</tr>
<tr>
<td>Child’s DOB (mm/dd/yy)</td>
<td></td>
</tr>
<tr>
<td>Child’s Medical Record No.</td>
<td></td>
</tr>
<tr>
<td>Child’s Name (Last, First, MI)</td>
<td></td>
</tr>
<tr>
<td>Sex (M/F)</td>
<td></td>
</tr>
<tr>
<td>Child’s DOB (mm/dd/yy)</td>
<td></td>
</tr>
<tr>
<td>Child’s Medical Record No.</td>
<td></td>
</tr>
<tr>
<td>Health Center Name</td>
<td></td>
</tr>
<tr>
<td>Health Center Address – Street</td>
<td></td>
</tr>
<tr>
<td>City, State, ZIP</td>
<td></td>
</tr>
<tr>
<td>Child’s Attending Physician</td>
<td></td>
</tr>
<tr>
<td>Physician’s Medical Lic. No.</td>
<td></td>
</tr>
<tr>
<td>Certified Midwife</td>
<td></td>
</tr>
<tr>
<td>Certification No</td>
<td></td>
</tr>
<tr>
<td>Health Center Name</td>
<td></td>
</tr>
<tr>
<td>Health Center Address – Street</td>
<td></td>
</tr>
<tr>
<td>City, State, ZIP</td>
<td></td>
</tr>
<tr>
<td>FQHC Telephone No.</td>
<td></td>
</tr>
<tr>
<td>Date Form Mailed</td>
<td></td>
</tr>
</tbody>
</table>

Has the mother relinquished her rights to the newborn child?  

- [ ] Yes  
- [ ] No  

If “Yes,” give date of relinquishment.  

---

**OP.1**  

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**OP.2 Special Medical Prior Authorization (SMPA) Request Form**

Use only for requests submitted to the TMHP-SMPA department. Mail completed form to the TMHP Special Medical Prior Authorization at 12357-B Riata Trace Parkway Ste. 150, Austin, TX 78727 or fax to 1-512-514-4213.

<table>
<thead>
<tr>
<th>Section A: Client information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Medicaid number:</td>
</tr>
<tr>
<td>Date of birth: / /</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section B: Requested procedure or service information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of request: [ ] Transplant [ ] Surgery [ ] Other</td>
</tr>
<tr>
<td>Expected dates of service:</td>
</tr>
<tr>
<td>Procedure requested - CPT code</td>
</tr>
<tr>
<td>--------------------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
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</tbody>
</table>

Comments:

<table>
<thead>
<tr>
<th>Section C: To be completed by requesting physician or prescribing provider- Additional information may be attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses (ICD-9-CM):</td>
</tr>
<tr>
<td>Statement of medical necessity (Refer to the appropriate section of the Texas Medicaid Provider Procedures Manual for specific prior authorization requirements):</td>
</tr>
<tr>
<td>Physician’s name:</td>
</tr>
<tr>
<td>Address/City/ZIP:</td>
</tr>
<tr>
<td>Telephone number:</td>
</tr>
<tr>
<td>Fax number:</td>
</tr>
<tr>
<td>TPI: NPI: Taxonomy:</td>
</tr>
<tr>
<td>Physician’s signature:</td>
</tr>
<tr>
<td>Date signed:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section D: Service provider or facility information - If different than provider in Section C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider printed name:</td>
</tr>
<tr>
<td>Contact person:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Address/City/ZIP:</td>
</tr>
<tr>
<td>Telephone number:</td>
</tr>
<tr>
<td>Fax number:</td>
</tr>
<tr>
<td>TPI: NPI: Taxonomy:</td>
</tr>
</tbody>
</table>
10. CLAIM FORM EXAMPLES
### Ambulatory Surgical Center

#### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>1A</td>
<td>INSURED'S I.D. NUMBER (For Program in Item 1) 123456789</td>
</tr>
<tr>
<td>1B</td>
<td>MEDICARE</td>
</tr>
<tr>
<td>1C</td>
<td>MEDICAID</td>
</tr>
<tr>
<td>2A</td>
<td>PATIENT'S NAME (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>2B</td>
<td>PATIENT'S BIRTH DATE</td>
</tr>
<tr>
<td>2C</td>
<td>SEX</td>
</tr>
<tr>
<td>3A</td>
<td>PATIENT'S ADDRESS (No., Street)</td>
</tr>
<tr>
<td>3B</td>
<td>CITY</td>
</tr>
<tr>
<td>3C</td>
<td>STATE</td>
</tr>
<tr>
<td>3D</td>
<td>ZIP CODE</td>
</tr>
<tr>
<td>4A</td>
<td>PATIENT'S ADDRESS (No., Street)</td>
</tr>
<tr>
<td>4B</td>
<td>CITY</td>
</tr>
<tr>
<td>4C</td>
<td>STATE</td>
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<tr>
<td>4D</td>
<td>ZIP CODE</td>
</tr>
<tr>
<td>5A</td>
<td>EMPLOYER'S NAME OR SCHOOL NAME</td>
</tr>
<tr>
<td>5B</td>
<td>OTHER INSURED'S DATE OF BIRTH</td>
</tr>
<tr>
<td>5C</td>
<td>EMPLOYMENT? (Current or Previous)</td>
</tr>
<tr>
<td>6A</td>
<td>OTHER INSURED'S POLICY OR GROUP NUMBER</td>
</tr>
<tr>
<td>6B</td>
<td>EMPLOYER’S NAME OR SCHOOL NAME</td>
</tr>
<tr>
<td>6C</td>
<td>OTHER INSURED'S DATE OF BIRTH</td>
</tr>
<tr>
<td>6D</td>
<td>EMPLOYER’S NAME OR SCHOOL NAME</td>
</tr>
<tr>
<td>6E</td>
<td>OTHER INSURED'S POLICY OR GROUP NUMBER</td>
</tr>
<tr>
<td>7A</td>
<td>RESERVATION FOR LOCAL USE</td>
</tr>
<tr>
<td>8A</td>
<td>INSURED'S NAME (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>8B</td>
<td>INSURED'S DATE OF BIRTH</td>
</tr>
<tr>
<td>8C</td>
<td>SEX</td>
</tr>
<tr>
<td>9A</td>
<td>OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>9B</td>
<td>OTHER INSURED'S POLICY OR GROUP NUMBER</td>
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<tr>
<td>9C</td>
<td>EMPLOYMENT? (Current or Previous)</td>
</tr>
<tr>
<td>10A</td>
<td>RESERVED FOR LOCAL USE</td>
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<tr>
<td>11A</td>
<td>INSURED'S POLICY GROUP OR FECA NUMBER</td>
</tr>
<tr>
<td>12A</td>
<td>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</td>
</tr>
<tr>
<td>13A</td>
<td>MEDICARE</td>
</tr>
<tr>
<td>13B</td>
<td>MEDICAID</td>
</tr>
<tr>
<td>13C</td>
<td>TRICARE</td>
</tr>
<tr>
<td>13D</td>
<td>CHAMPVA</td>
</tr>
<tr>
<td>13E</td>
<td>FECA</td>
</tr>
<tr>
<td>13F</td>
<td>OTHER</td>
</tr>
<tr>
<td>14A</td>
<td>DATE OF CURRENT ILLNESS (First symptom or injury)</td>
</tr>
<tr>
<td>14B</td>
<td>DURATION OF ILLNESS</td>
</tr>
<tr>
<td>14C</td>
<td>ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)</td>
</tr>
<tr>
<td>15A</td>
<td>IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</td>
</tr>
<tr>
<td>15B</td>
<td>GIVE FIRST DATE</td>
</tr>
<tr>
<td>16A</td>
<td>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
</tr>
<tr>
<td>16B</td>
<td>FROM</td>
</tr>
<tr>
<td>16C</td>
<td>TO</td>
</tr>
<tr>
<td>17A</td>
<td>NAME OF REFERENCING PROVIDER OR OTHER SOURCE</td>
</tr>
<tr>
<td>17B</td>
<td>NPI</td>
</tr>
<tr>
<td>18A</td>
<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
</tr>
<tr>
<td>18B</td>
<td>FROM</td>
</tr>
<tr>
<td>18C</td>
<td>TO</td>
</tr>
<tr>
<td>19A</td>
<td>PROVIDER ID. #</td>
</tr>
<tr>
<td>19B</td>
<td>ORIGINAL REF. NO.</td>
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<tr>
<td>20A</td>
<td>INSURED'S I.D. NUMBER</td>
</tr>
<tr>
<td>20B</td>
<td>SOCIAL SECURITY NUMBER</td>
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<tr>
<td>21A</td>
<td>MEDICAID RESUBMISSION CODE</td>
</tr>
<tr>
<td>22A</td>
<td>PRIORITY NUMBER</td>
</tr>
<tr>
<td>23A</td>
<td>PRIOR AUTHORIZATION NUMBER</td>
</tr>
<tr>
<td>24A</td>
<td>DURATION OF SERVICE</td>
</tr>
<tr>
<td>24B</td>
<td>BUDGET CODE</td>
</tr>
<tr>
<td>24C</td>
<td>UNIT COST</td>
</tr>
<tr>
<td>24D</td>
<td>TOTAL CHARGE</td>
</tr>
<tr>
<td>25A</td>
<td>FEDERAL TAX I.D. NUMBER</td>
</tr>
<tr>
<td>26A</td>
<td>PATIENT'S ACCOUNT NO.</td>
</tr>
<tr>
<td>27A</td>
<td>ACCEPT ASSIGNMENT</td>
</tr>
<tr>
<td>28A</td>
<td>TOTAL CHARGE</td>
</tr>
<tr>
<td>29A</td>
<td>AMOUNT PAID</td>
</tr>
<tr>
<td>30A</td>
<td>BALANCE DUE</td>
</tr>
</tbody>
</table>

**Signed by:** Raquel Del Sol

**Date:** 01 10 2009

NUCC Instruction Manual available at: www.nucc.org

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

CPT ONLY - COPYRIGHT 2009 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.
**OP.4 Family Planning Services for Hospitals, FQHCs**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Diagnosis Code</th>
<th>Procedure Code</th>
<th>Date</th>
<th>Units</th>
<th>Medicare Amount</th>
<th>Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>520</td>
<td>Annual Family Planning Exam</td>
<td>1-99203 FP</td>
<td>01012009</td>
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<td>307</td>
<td>Urinalysis</td>
<td>5-81015 FP</td>
<td>01012009</td>
<td>1</td>
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<td>4.31</td>
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</tbody>
</table>

Total Charges: $51.88

---

**Outpatient Services Handbook**

**Federally Qualified Health**

1242 Medical Drive

The Colony, Texas 75321

---

**Statement of Services**

Statement of Services - 0731

---

**Certification**

The certifications on the reverse apply to the bill and are made a part hereof.
## OP.5  FQHC Encounter (T1015)

### Encounter Details

| 10 Birthdate | 11 Sex | 12 Date | 13 HR | 14 Type | 15 Spec | 16 CHR | 17 Stat | 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 |
|--------------|--------|--------|-------|---------|---------|--------|---------|---------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| 01012009     | M      |        |       |         |         |        |         |         |           |           |           |           |           |           |           |           |           |           |           |           |           |           |           |           |           |           |

### Encounter Creation Details

<table>
<thead>
<tr>
<th>50 Patient Name</th>
<th>51 Health Plan ID</th>
<th>52 Specialty</th>
<th>53 Prior Payments</th>
<th>54 Est. Amount Due</th>
<th>55 NPI</th>
<th>56 Payer Name</th>
<th>57 Group Name</th>
<th>58 Insurance Group No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doe, John M.</td>
<td>Medicaid</td>
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</table>

### Encounter Charges

<table>
<thead>
<tr>
<th>26 Code</th>
<th>27 Value Codes</th>
<th>28 AMOUNT</th>
<th>29 Code</th>
<th>30 Value Codes</th>
<th>31 AMOUNT</th>
<th>32 Code</th>
<th>33 Value Codes</th>
<th>34 AMOUNT</th>
<th>35 Occurrence Code</th>
<th>36 Occurrence Date</th>
<th>37 Occurrence Span</th>
<th>38 Occurrence Through</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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### Total Charges

35 00

### Other Procedure Details

<table>
<thead>
<tr>
<th>42 Code</th>
<th>43 Description</th>
<th>44 HCPCS / Rate / HIPIFS Code</th>
<th>45 Serv. Date</th>
<th>46 Serv. Units</th>
<th>47 Total Charges</th>
<th>48 Non-Covered Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### Encounter Details

<table>
<thead>
<tr>
<th>52 Occurrence Code</th>
<th>53 Occurrence Date</th>
<th>54 Occurrence Span From</th>
<th>55 Occurrence Span Through</th>
<th>56 Code</th>
<th>57 Value Codes</th>
<th>58 AMOUNT</th>
<th>59 Code</th>
<th>60 Value Codes</th>
<th>61 AMOUNT</th>
<th>62 Code</th>
<th>63 Value Codes</th>
<th>64 AMOUNT</th>
<th>65 Code</th>
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</tr>
</tbody>
</table>

### Total Charges

35 00
## FQHC Follow-Up

### Patient Information
- **Name:** Doe, Jane
- **Address:** 1902 Park Place, Valley, Texas 78321
- **Date of Birth:** 01041976
- **Sex:** F
- **SSN:** 123456

### Encounter Details

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Occurrence Code</th>
<th>Occurrence Date</th>
<th>Occurrence Value</th>
<th>Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>520</td>
<td>Antepartum Encounter</td>
<td>1-T1015</td>
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<td>1</td>
<td></td>
<td>25.00</td>
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<tr>
<td>520</td>
<td>Delivery</td>
<td>1-T1015</td>
<td>01012009</td>
<td>1</td>
<td></td>
<td>550.00</td>
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</tbody>
</table>

### Total Charges
- **Total:** 575.00

### Medicaid Information
- **INSURED'S NAME:** Doe, Jane
- **INSURED'S UNIQUE ID:** 12345678
- **GROUP NAME:** Medicaid
- **INSURANCE GROUP NO.:** 9876543-21

## Billing Details
- **NPI:** 1234567890
- **TOTAL CHARGES:** 575.00
- **TOTAL AMOUNT DUE:** 1324657908

### Other Information
- **Pregnancy, Delivery**
### OP.7 Hospital-Based ASC

**Greatland Hospital Center**  
4004 Elm Loop  
Westville, TX  
512-555-1234

<table>
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<th>ADMISSION CODE</th>
<th>DATE</th>
<th>OCCURRENCE CODE</th>
<th>OCCURRENCE CODE</th>
<th>OCCURRENCE CODE</th>
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<td>871 87</td>
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**Pat. Name:** Doe, John  
**Address:** 6789 Courtland Circle, Westville, TX 79065  
**Birth Date:** 12/16/1964  
**Sex:** M  
**Admit Date:** 01/01/2009  
**Patient #:** 11  
**Diagnosis Code:** 38900  
**Operation Code:** 38421  
**Other Procedure Code:** 38903

**Medicaid**  
**NPI:** 1234567890

**Total Charges:** 871 87
# OP.8 Hospital Outpatient

**Texas Hospital**  
209 W. 45th  
El Paso, Texas 77905  
915-555-1234

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### Detailed Information

**Patient Name:** Doe, Jane  
**Address:** 6789 Ave. A, Austin, TX 78711

### Admission Details

- **Date:** 03271965  
- **Type:** F  
- **Fed. Tax No.:** 0131  
- **Birth Date:** 03/27/1965  
- **Sex:** F

### Procedure Details

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### Total Charges

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<tbody>
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### Certification

- The certifications on the reverse apply to this bill and are made a part hereof.
### OP.9 Renal Dialysis Facility CAPD Training

**Renal Hospital**  
1113 Hospital Dr.  
Victoria, TX 77123  
1-495-555-1234

**Patient Information**  
- **Name:** Doe, Jane  
- **Address:** 111 Broadway Victoria TX 77123  
- **Birthdate:** 05191963  
- **Gender:** F  
- **Social Security Number:** - 06042009

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<th><strong>Units</strong></th>
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**Total:** 10  
**Total Amount:** 1,290.00

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### OP.10 Renal Dialysis Facility CAPD/CCPD

**Rural Community Clinic**  
1242 Medical Loop  
Point West, Texas 77364

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<th>Patient Name</th>
<th>Address</th>
<th>Zip Code</th>
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<td>6789 Courtland Circle, New Caney, TX 79065</td>
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**BirthDate** | **Sex** | **Admission** | **Type** | **SubType** | **Occupancy** | **Stat** | **Condition Codes** | **Occurrence** | **Occurrence** | **Occurrence** | **Occurrence** | **Occurrence** | **Occurrence** |
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**Total Charges**  
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**Payor Information**  
**Medicaid**

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**Treatment Authorization Codes**  
1234567890

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**Remarks**  
Pain in Arm

---

**OUTPATIENT SERVICES HANDBOOK**

**OP-49**

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Renal Dialysis CMS-1500 Example

**OP.11 Renal Dialysis CMS-1500 Example**

**HEALTH INSURANCE CLAIM FORM**

**MEDICAID OF TX**

PO BOX 20055
AUSTIN, TX 78720-0555

**1. MEDICARE**
- (Medicare #) (Medicaid #) (Sponsor’s SSN) (Member ID)

**2. PATIENT’S NAME**
- Last Name, First Name, Middle Initial

**3. PATIENT’S BIRTH DATE**
- MM DD YY

**4. PATIENT’S GENDER**
- Male (M) Female (F)

**5. PATIENT’S ADDRESS (No., Street)**
- 341 Tosca Way

**6. PATIENT RELATIONSHIP TO INSURED**
- Self X Spouse Child Other

**7. INSURED’S ADDRESS (No., Street)**
- AUSTIN, TX 78720-0555

**8. PATIENT STATUS**
- Single X Married Other

**9. OTHER INSURED’S NAME**
- Doe, Jane

**10. OTHER INSURED’S DATE OF BIRTH**
- 02 02 1971

**11. OTHER INSURED’S POLICY GROUP OR FECA NUMBER**
- 123456789

**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 OR AUTHORIZED PERSON’S SIGNATURE**
- I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

**SIGNED DATE**
- 07/10/2009

**16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**
- 06 21 2009 06 21 2009

**17. NAME OF REFERRING PROVIDER OR OTHER SOURCE**
- J2916

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

**22. MEDICAID RESUBMISSION**
- 123456789

**25. FEDERAL TAX I.D. NUMBER**
- SSN EIN

**26. PATIENT’S ACCOUNT NO.**
- 1234567-01

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

**30. OUTSIDE LAB? $ CHARGES**
- YES X NO

**36. SERVICE FACILITY LOCATION INFORMATION**
- Renal Healthcare

**37. 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 hereof.)

**Signature on File**
- Signed

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

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## OP.12 Rural Health Clinic Freestanding

### Patient Information
- **Name:** Doe, John
- **Address:** 6789 Courtland Circle, New Caney, TX 77065
- **Date of Birth:** 12/16/1991
- **Sex:** M
- **ID Number:** 1234567-89
- **Insurance:** Medicaid
- **Contact Number:** 1234567890

### Procedure
- **Code:** 521 Clinic Visit
  - **Date:** 01/01/2009
  - **Duration:** 10 minutes
  - **Total Charges:** $75.00

### Certification
- **Date of Service:** 01/01/2009
- **Certifications:**
  - **Applicant:** Doe, John
  - **Signature:**
  - **Date:** 01/01/2009

### Practice Information
- **Address:** Rural Community Clinic
- **Location:** 1242 Medical Loop
- **City:** Point West, Texas 77364
- **NPI:** A64322

---

The certifications on the reverse apply to this bill and are made a part hereof.
### OP.13 Rural Health Clinic Freestanding (Immunization)

<table>
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<tr>
<th>Patient Name</th>
<th>Address</th>
<th>Diagnosis</th>
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<tbody>
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<td>Conjunctivitis</td>
<td>DTP #3</td>
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**Total Charges: 80.00**
### OP.14 Rural Health Clinic Hospital-Based

#### Patient Information
- **Name:** Doe, John
- **Address:** 6789 Courtland Circle, New Caney, TX 79065
- **Date of Birth:** 01012009
- **Social Security Number:** 10081964
- **Sex:** M
- **Race:** 01012009
- **Attending Physician:** Doe, John

#### Diagnosis
- **Reason for Visit:** Clinic Visit
- **Date:** 01012009

#### Charges
- **Total Charges:** $36.00

#### Additional Information
- **Provider Name:** Medicaid
- **Provider ID:** 123456789
- **Group Name:** Doe, John
- **Insurance Group No.:** 1342657098
- **Statement Covers Period:** 01012009
- **Est. Amount Due:** $987654321

---

**NOTE:** The certifications on the reverse apply to this form and are made a part hereof.
HEALTH INSURANCE CLAIM FORM

CARRIER

<table>
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<tr>
<th>1.</th>
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<th>MEDICAID</th>
<th>TRICARE</th>
<th>CHAMPUS</th>
<th>CHAMPVA</th>
<th>GROUP HEALTH PLAN</th>
<th>FECA BLACK-OUT</th>
<th>OTHER</th>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Doe, Jane C.

3. PATIENT’S ADDRESS (No., Street)

1200 Baltic Avenue

4. PATIENT’S BIRTH DATE

12-01-65

SEX

M

5. RESERVED FOR LOCAL USE

6. PATIENT RELATIONSHIP TO INSURED

Self

7. PATIENT’S ADDRESS (No., Street)

8. PATIENT STATUS

Single

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

10. IS PATIENT’S CONDITION RELATED TO:

11. INSURED’S POLICY GROUP OR FECA NUMBER

12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim.

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 ILLNESS (First symptom or Injury (Accident) OR ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY/LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

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. B. C. D. E.

25. F. G. H. I. J.

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 #

Sally Green, ANP

1242 Rosewood

Conroe, TX 77307

Signed

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