The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.
# Inpatient and Outpatient Hospital Services Handbook

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1. GENERAL INFORMATION

The information in this handbook is intended for Texas Medicaid hospital (medical and surgical acute care facility) providers and covers services that take place only in an inpatient or outpatient hospital setting. The handbook provides information about Texas Medicaid’s benefits, policies, and procedures applicable to acute care hospitals, including military hospitals.

Important: All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to 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(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.

Refer to: The Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks), for information about services offered in settings such as rural health clinics (RHCs), Federally Qualified Health Centers (FQHCs), dialysis centers, and other similar facilities.

1.1 National Drug Codes (NDC)


1.2 Medicaid Managed Care Services

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in “Carve-Out Services” in the Medicaid Managed Care Handbook, (Vol. 2, Provider Handbooks).

2. ENROLLMENT

To be eligible to participate in Texas Medicaid, a hospital must be certified by Medicare, have a valid provider agreement with the Health and Human Services Commission (HHSC), and have completed the Texas Medicaid & Healthcare Partnership (TMHP) enrollment process.
2.1 Hospital Eligibility Through Change of Ownership
Under procedures set forth by the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS), a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued if the hospital obtains recertification as a Title XVIII (Medicare) hospital and a new Title XIX (Medicaid) agreement between the hospital and HHSC.

To obtain the Medicaid hospital participation agreement, providers may call the TMHP Contact Center at 1-800-925-9126, Monday through Friday, 7 a.m. to 7 p.m., Central Time.

Refer to: Subsection 1.3, “Provider Reenrollment,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

2.1.1 Hospital-based Ambulatory Surgical Center (HASC) Enrollment
All hospitals enrolling in Texas Medicaid (except psychiatric and rehabilitation hospitals) are issued an HASC provider number at the time of enrollment.

2.2 Hospital-based Rural Health Clinic Enrollment
To enroll in Texas Medicaid and qualify for participation as a Title XIX RHC, RHCs must be enrolled in Medicare. A nine-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.


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


3. INPATIENT HOSPITAL (MEDICAL/SURGICAL ACUTE CARE INPATIENT FACILITY)
This section contains benefit, limitation, authorization, and claims filing information for inpatient hospital facility accommodation and ancillary services.

Refer to: Section 6: Claims Filing and Section 7: Appeals (Vol. 1, General Information) for more comprehensive information about claims filing and appeals.

Hospital providers are encouraged to review the other handbooks for applicable information, prior authorization requirements, and for specific requirements for special programs.
3.1 General Information

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Texas Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of patients. Services must be medically necessary and are subject to Texas Medicaid’s utilization review requirements. Claims submitted to TMHP must comply with the applicable Texas Medicaid policies and procedures.

3.1.1 Reimbursement Limitations

For clients who are 21 years of age or older, Texas Medicaid reimbursement for acute care inpatient hospital services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments that exceed $200,000 are recouped.

This $200,000 limitation does not apply to the following:

- Services related to certain organ transplants.
- Services rendered to THSteps clients when provided through CCP.

For clients who are 20 years of age or younger, dollar limitations do not apply.

3.1.2 Spell of Illness

Reimbursement to hospitals for inpatient services is limited to the Medicaid spell of illness. The spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

Exceptions to the spell of illness are as follows:

- A prior-approved solid organ transplant. The 30-day spell of illness for transplants begins on the date of the transplant, allowing additional time for the inpatient stay.
- THSteps-eligible clients who are 20 years of age and younger when a medically necessary condition exists.

Texas Medicaid will conduct a quarterly utilization review of inpatient claims to determine whether the claims were paid outside of the spell-of-illness limitation.

The first of these utilization reviews were for claims with dates of service from April 27, 2010, through January 6, 2012.

3.1.3 Take-Home Drugs, Self-Administered Drug, or Personal Comfort Items

Take-home drugs and comfort items that are provided by the hospital during an inpatient hospital stay are included in the hospital reimbursement and are not reimbursed separately.

Take-home drugs and supplies may be a benefit through the Vendor Drug Program (VDP) when supplied by prescription.

Self-administered drugs are defined as drugs that the client administers themselves at home and may include, but are not limited to, prescription drugs, vitamins, and supplements. Self-administered drugs provided by the hospital during an inpatient hospital stay are included in the hospital reimbursement and are not reimbursed separately.

The client cannot be billed for take home drugs, comfort supplies or self-administered drugs that are provided by the hospital during an inpatient hospital stay.
3.1.4 Services Included in the Inpatient Stay

The following services are included in the inpatient stay and are not separately reimbursed:

- **Whole blood and packed red blood cells.** Inpatient services include whole blood and packed red blood cells that are reasonable and necessary for treatment of illness or injury. Whole blood and packed red blood cells that are available without cost are not reimbursed by Texas Medicaid. Blood storage is not a benefit of Texas Medicaid.

- **Laboratory, radiology, and pathology services.** Inpatient services include all medically necessary services and supplies ordered by a physician to include laboratory, radiology, and pathology services.

  **Note:** Ultrasound interpretations in the inpatient hospital setting will be denied if they are billed by the attending physician. Services that are billed by the attending physician are included in the facility fee and are not reimbursed separately.

  **Note:** 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.

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

**Refer to:** Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA),” in Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for more information about CLIA.

Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

3.2 Services, Benefits, Limitations, and Prior Authorization - Acute Care

Inpatient hospital services include the following:

- Bed and board
- Whole blood and packed red blood cells
- All medically necessary services ordered by a physician to include laboratory, radiology, and pathology
- All medically necessary supplies ordered by a physician
- Medically necessary emergency and non-emergency ambulance transports during the inpatient stay
- Maternity care
- Newborn care
- Inpatient surgery and rehabilitation
- Organ and tissue transplant services
- Colorectal cancer screening services

3.2.1 Bed and Board

Inpatient bed and board include semiprivate accommodations or accommodations in an intensive care or coronary care unit. The accommodations include:

- Meals
- Special diets
- General nursing services
Private accommodations including meals, special diets, and general nursing services may be reimbursed up to the hospital’s charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations may be reimbursed in full if required for medical reasons as certified by the physician. The hospital must document the medical necessity for a private room (i.e., the existence of a critical or contagious illness, a condition that could result in disturbance to other patients). The medical necessity for the private accommodations must be included in Block 80 of the UB-04 CMS-1450 paper claim form or added as an attachment to the claim submission.

3.2.2 Hysterectomy Services

Hysterectomy services are considered for reimbursement when the claim is filed with a signed Hysterectomy Acknowledgment Form or submitted documentation indicates that the Hysterectomy Acknowledgment Form could not be obtained.

Claims for services related to the hysterectomy cannot be reimbursed unless the signed Hysterectomy Acknowledgement Form is on file; consequently, to avoid claim denials, each individual provider is encouraged to submit a copy of the valid Hysterectomy Acknowledgement Form and not rely on another provider to do so.

Refer to: Subsection 5.10.1, “Hysterectomy Acknowledgment Form,” in Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks) for additional information.

Subsection HS.2, “Hysterectomy Acknowledgment Form,” in this handbook.

3.2.3 Maternity Care

Inpatient maternity care includes usual and customary care for all female clients.

3.2.3.1 Emergency Coverage

For women with a family income at or below 185 percent of the Federal Poverty Level (FPL), hospital facility charges are paid through Emergency Medicaid. A client must be determined eligible for Emergency Medicaid by HHSC for a claim to be paid to a Medicaid provider. Claims are sent to TMHP for processing.

3.2.3.2 Mother and Newborn Hospital Stay

Circumstances that require the mother and newborn to remain in the hospital longer than two days for a routine vaginal delivery or four days for a cesarean section must be documented in the clients’ medical records.

Continuation of hospitalization is a benefit for the infant when the mother is required to remain hospitalized for medical reasons. The reason for the continuation of hospitalization must be documented in the client’s medical record.

3.2.3.3 Children’s Health Insurance Program (CHIP) Perinatal Coverage

For clients who are eligible for CHIP perinatal services as determined by HHSC, CHIP perinatal services include newborn services and inpatient hospital charges related to the delivery of the newborn. Preterm or false labor that does not result in a birth are not CHIP perinatal services.

Inpatient services limited to labor with delivery for women with income between 186 and 200 percent of FPL will be covered under CHIP perinatal. Newborn services will also be covered under CHIP perinatal.

For CHIP perinatal newborns with a family income at or below 185 percent of the federal poverty level, TMHP will process newborn transfer hospital claims even if the claim from the initial hospital stay has not been received. The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay.
Transfer claims must be filed to TMHP using the admission type 1, 2, 3, or 5 in block 14; source of admission code 4 or 6 in block 15; and the actual date and time the client was admitted in block 12 of the UB-04 CMS-1450 paper claim form.


3.2.4 Newborn Care

Newborn care includes routine newborn care, routine screenings, and specialized nursery care for newborns with specific problems.

Hospital providers must provide all state-mandated newborn screenings and vaccinations.

Refer to: “Hearing Screening” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).


3.2.4.1 Newborn Eligibility

A child is deemed eligible for Texas Medicaid through 12 months of age if the mother is receiving Medicaid at the time of the child’s birth, the child continues to live with the mother, and the mother continues to be eligible for Medicaid or would be eligible for Medicaid if she were pregnant. Therefore, it is not acceptable for a hospital to require a deposit for newborn care from a Medicaid client. The child’s eligibility ends if the mother relinquishes her parental rights or if it is determined that the child is no longer part of the mother’s household.

Hospitals must complete Form HS.1, “Hospital Report (Newborn Child or Children) (Form 7484)” in this handbook to provide information about each child born to a mother eligible for Medicaid. If the newborn’s name is known, the name must be on the form.

Important: If the newborn’s name is not known, the name may be left blank. The use of “Baby Boy” or “Baby Girl” delays the assignment of a number.

The form must be completed by the hospital no later than five days after the child’s birth and sent to HHSC at the address identified on the form. The form should not be completed for stillbirths. Hospitals should duplicate the form as needed, because they are not supplied by HHSC, the Department of Aging and Disability Services (DADS) or TMHP.

Hospitals that submit the birth certificate information using the Department of State Health Services (DSHS), Vital Statistics Unit (VSU) Texas Electronic Registrar for Birth software and the HHSC Form 7484, receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care including pharmacies that provide outpatient prescription benefits for medically-needy newborns.

Refer to: The HHSC website at www.hhsc.state.tx.us/medicaid/mc/proj/newid/newid.html for additional information about obtaining a newborn Medicaid identification number. Providers may also call 1-888-963-7111, Ext. 7368 or (512) 458-7368 for additional information or to comment about this process.

After receiving a completed form, HHSC verifies the mother’s eligibility. Within 10 days of receiving the completed form, HHSC sends notices to the hospital, mother, caseworker, and attending physician, if identified. The notice includes the child’s Medicaid client number and the effective date of coverage. After the child has been added to the eligibility file, HHSC issues a Medicaid Identification (Form H3087).

Claims submitted for services provided to a newborn child who is eligible for Medicaid must be filed using the newborn child’s Medicaid client number.
Newborns who are from families with an income at or below 185 percent of the FPL and who receive CHIP perinatal benefits are assigned a client number for Texas Medicaid. This number is only assigned for reimbursement of the newborn’s hospital facility charges (on a UB-04 CMS-1450 paper claim form) for the initial hospital stay after delivery. Claims for the newborn’s hospital facility charges should be sent to TMHP.

3.2.5 Organ and Tissue Transplant Services

3.2.5.1 Transplant Facilities

A facility that renders organ transplants must be a designated children’s hospital or a facility in continuous compliance with the criteria set forth by the following:

- Organ Procurement and Transportation Network (OPTN)
- United Network for Organ Sharing (UNOS)
- National Marrow Donor Program (NMDP)

Facilities whose status of “good standing” has been suspended for any reason by the national credentialing bodies will not be reimbursed by Texas Medicaid for transplant services until the status of “good standing” is restored.

If a Medicaid client receives a transplant in an in-state or out-of-state facility that is not approved by Texas Medicaid, the client must be discharged from the facility to be considered to receive other medical and hospital benefits under Texas Medicaid. Coverage for other services needed as a result of complications of the transplant may be considered when medically necessary, reasonable, and federally allowable. Texas Medicaid will not pay for routine post-transplant services for transplant patients in facilities that are not approved by Texas Medicaid.

3.2.5.1.1 Out-of-state Transplant Facilities

Out-of-state facilities may be reimbursed for transplants rendered to Texas Medicaid clients under certain conditions. In order for Texas Medicaid to reimburse for an out-of-state transplant, the out-of-state facility and professional providers must enroll as Texas Medicaid providers. The out-of-state transplant facilities must submit proof of transplant facility UNOS or NMDP certification as required by the Texas HHSC.

Physicians who are licensed by the state of Texas may request prior authorization for transplant services to be performed at out-of-state facilities when all of the following criteria are met:

- The required organ transplant is not available in Texas
- The facility is nationally recognized as a Center of Excellence
- The services are medically necessary, reasonable, and federally allowable
- The client is enrolled in Texas Medicaid

The pretransplant evaluation must be performed by a Texas facility. If it is medically necessary that the pretransplant evaluation be performed at the out-of-state facility as well, the prior authorization request for the out-of-state pretransplant evaluation must be submitted with a copy of the evaluation that was performed by the Texas facility. The documentation must support the need for an out-of-state pretransplant evaluation.

**Important:** Texas Medicaid does not cover transplant services provided out-of-state that are available in Texas.
3.2.5.2 Transplant Benefits and Limitations

If a transplant has been authorized as medically necessary by HHSC or its designee because of an emergent, life-threatening situation, a maximum of 30 days of inpatient hospital services during Title XIX spell of illness may be a benefit, beginning with the actual first day of the transplant. This benefit is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.

Refer to: Subsection 3.1.2, “Spell of Illness,” in this handbook for additional information about the 30-day spell of illness period.

Reimbursement for transplant is limited to an initial transplant as a lifetime benefit and one subsequent re-transplant because of rejection. Expenses incurred by a living donor will not be reimbursed.

All transplants require prior authorization. If a solid organ transplant is not prior authorized, services that are directly related to the transplant within the three-day pre-operative and six-week postoperative period will be denied, regardless of who provides the services. Services unrelated to the transplant surgery will be paid separately.

If the organ is rejected, the re-transplant requires its own prior authorization. If the re-transplant is not prior authorized, services that are directly related to the re-transplant within the three-day pre-operative and six-week postoperative period will be denied, regardless of who provides the services. Services unrelated to the re-transplant surgery will be paid separately.

Note: The re-transplant is not included in the prior authorization for the initial transplant. The subsequent re-transplant must be prior authorized separately.


3.2.5.3 Prior Authorization for Organ and Transplant Services

All solid organ transplant services provided by facilities and professionals must be prior authorized. If a solid organ transplant is not prior authorized, services directly related to the transplant within the three-day pre-operative and six-week postoperative period also will be denied, regardless of who provides the service, (e.g., laboratory services, status-post visits, and radiology services). Services unrelated to the transplant surgery will be paid separately.

A transplant request signed by a physician associated with transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution’s transplant protocol.


3.2.5.4 Transplants for Medicare-Eligible Clients

Transplants are also a benefit under the Medicare program; therefore, for clients eligible for Medicare and Medicaid, Texas Medicaid will pay only the deductible or coinsurance portion as applicable. Prior authorization must be obtained for Medicaid-only clients; authorization will not be given for Medicare/Medicaid-eligible clients. Texas Medicaid will not pay for a transplant service denied by Medicare for a Medicare-eligible client.

3.2.5.5 Experimental or Investigational Services

Benefits are not available for any experimental or investigational services (including xenotransplantation and artificial/bioartificial liver transplants), supplies, or procedures.
3.2.5.6 Reimbursement for Transplant Services

The hospital DRG payment for the transplant includes procurement of the organ and services associated with the organ procurement. The Omnibus Budget Reconciliation Act of 1986 (OBRA 86) Public Law 99-509 added Section 1138 of the Social Security Act, which defines conditions of participation for institutions in the organ procurement program. Organ procurement costs are not reimbursed to a hospital that fails to meet the conditions of participation. The specific guidelines may be found in the appropriate areas of the Code of Federal Regulations (CFR) Title 42, Parts 405, 413, 441, 482, and 485. Documentation of organ procurement must be maintained in the hospital’s medical record.

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

3.3 Services, Benefits, Limitations, and Prior Authorization - Inpatient Rehabilitation Services

Inpatient rehabilitation services are a benefit of Texas Medicaid when provided as part of a general acute care inpatient admission, or with prior authorization for clients who are 20 years of age and younger in a freestanding rehabilitation facility.

Inpatient rehabilitation services in an acute care setting are included in the hospital DRG payment. All rehabilitation services are subject to Medicaid benefit limitations including the spell of illness. Exceptions to those limitations may be offered under CCP.


3.4 * Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services (IMD)

3.4.1 * Enrollment

Acute care hospitals and state psychiatric facilities must be certified by Medicare, have a valid provider agreement with the HHSC, and have completed the TMHP enrollment process.

Refer to: Subsection 5.1, “Enrollment,” for more information about acute care hospital enrollment.

Freestanding psychiatric facilities must be licensed by DSHS or by the appropriate state board where services are rendered. The provider must be approved by The Joint Commission (TJC).

Providers cannot be enrolled if their licenses are due to expire within 30 days.

To be eligible to participate in the Comprehensive Care Inpatient Psychiatric (CCIP) Program to render services to Texas Health Steps (THSteps) clients, a freestanding or state psychiatric facility must be accredited by TJC, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Facilities certified by Medicare must also meet TJC accreditation requirements.

Note: Acute care hospitals cannot enroll as CCIP facilities.
3.4.2 * General Information

Inpatient admissions to acute care hospitals, freestanding psychiatric facilities, and state psychiatric facilities for psychiatric conditions may be a benefit of Texas Medicaid as outlined in the following table:

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>CCIP Clients 0-20 Years of Age</th>
<th>Medicaid Clients of Any Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care hospital</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Freestanding psychiatric facility (IMD)</td>
<td>Yes</td>
<td>Yes (clients 65 years of age and older) No (clients 21 through 64 years of age)</td>
</tr>
<tr>
<td>State psychiatric facility (IMD)</td>
<td>Yes</td>
<td>Yes (clients 65 years of age and older) No (clients 21 through 64 years of age)</td>
</tr>
</tbody>
</table>

(9MD) Institution for Mental Diseases.

When a client requires admission, or once the client becomes Medicaid eligible while in the facility, a certification of need must be completed and placed in the client’s record within 14 days of the admission.

Inpatient psychiatric treatment is a benefit of Texas Medicaid if all of the following are met:

- The client has a psychiatric condition that requires inpatient treatment.
- The inpatient treatment is directed by a psychiatrist.
- The inpatient treatment is provided in a nationally accredited facility or hospital.
- The provider is enrolled in Texas Medicaid.

Client services must be provided in the most appropriate setting and in a timely manner to meet the mental health needs of the client.

Inpatient admissions to acute care hospitals, freestanding, and state psychiatric facilities are subject to the Texas Medicaid retrospective utilization review (UR) requirements. The UR requirements are applicable, regardless of the hospital's designation as a psychiatric unit versus a medical or surgical unit.

3.4.2.1 * Professional Services Rendered in the Inpatient Setting

Services rendered in the inpatient hospital setting may be reimbursed to the professional that provides the service.

Refer to: Subsection 6.14, “Psychiatric Services for Hospitals,” in the Behavioral Health, Rehabilitation, and Case Management Services Handbook (Vol. 2, Provider Handbooks) for benefit and limitation information about services that are rendered by psychiatrists, psychologists, LPAs, APNs, and PAs in the inpatient setting.

3.4.2.2 * Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including all hospital services. Hospital services are subject to retrospective review and recoupment if documentation does not support the service that was submitted for reimbursement.

Documentation of medical necessity for inpatient psychiatric care must specifically address the following issues:

- Why the ambulatory care resources in the community cannot meet the treatment needs of the client.
- Why inpatient psychiatric treatment under the care of a psychiatrist is required to treat the acute episode of the client.
• How the services can reasonably be expected to improve the condition or prevent further regression of the client’s condition in a proximate time period.

Supporting documentation (certification of need) must be documented in the individual client’s record. This documentation must be maintained by each facility for a minimum of five years and be readily available for review whenever requested by the HHSC or its designee.

Psychological or neuropsychological testing, when performed in an acute care hospital or in a freestanding or state psychiatric facility does not require prior authorization; however, these facilities must maintain documentation that supports medical necessity for the testing and the testing results of any psychological or neuropsychological testing services performed while the client is an inpatient.

3.4.2.3 * Noncovered Services

Inpatient admissions including, but not limited to, the following are not benefits of Texas Medicaid without an accompanying medical complication or condition:

• Single diagnosis of chemical dependency or abuse (such as alcohol, opioids, barbiturates, and amphetamines).
• Chronic diagnoses (such as mental retardation, organic brain syndrome, or chemical dependency or abuse).

3.4.2.4 * CLIA Certification for Laboratory Services

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Providers that do not comply with CLIA are not reimbursed for laboratory services.

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate-holders.

Refer to: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure code and modifier QW requirements.

3.4.3 * Acute Care Hospital Psychiatric Services

Acute care hospital psychiatric services are those services that are rendered to Texas Medicaid clients of any age who are admitted as an inpatient to an acute care hospital for treatment of a psychiatric condition.

Admissions to acute care hospitals must be medically necessary.


3.4.3.1 * Prior Authorization Requirements

Prior authorization is not required for fee-for-service clients admitted to psychiatric units in acute care hospitals.

3.4.4 * Freestanding and State Psychiatric Facilities

Psychiatric facility services are those services that are rendered in an Institutions for Mental Diseases (IMD). Freestanding and state psychiatric facilities are enrolled in Texas Medicaid as IMDS. According to TAC Rule §419.453 and based on 42 CFR §435.1009, an IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental illness, including medical attention, nursing care, and related services.
3.4.4.1 * CCIP Services

Inpatient psychiatric treatment in a nationally accredited freestanding psychiatric facility or a nationally-accredited state psychiatric hospital is a benefit of Texas Medicaid for clients who are 20 years of age and younger, and who are eligible for THSteps benefits at the time of the service request and service delivery.

Admissions to freestanding and state psychiatric facilities must be medically necessary, unless they are court-ordered services for mental health commitments or they are a condition of probation.

Revenue code 124 must be used for inpatient psychiatric services that are rendered to children and adolescents in freestanding and state psychiatric facilities.

Note: Outpatient services for hospital-based psychiatric day treatment programs or psychiatric facilities are not a benefit of Texas Medicaid.

3.4.4.1.1 * Prior Authorization Requirements for Children and Adolescents

Prior authorization is required under CCIP for admission to freestanding psychiatric facilities or state psychiatric hospitals for clients who are birth through 20 years of age.

A toll-free telephone and fax line are available to complete the authorization process. Contact the TMHP CCIP Unit at (800) 213-8877 or fax to (512) 514-4211.

Authorization procedures and approved providers may be different for managed care clients. Contact the client’s specific health care plan for details.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of medical necessity for the services requested.

Initial admissions may be prior authorized for a maximum of five days based on Medicaid eligibility and documentation of medical necessity.

The prior authorization requests will be reviewed as follows:

- All psychiatric admission requests for clients who are 11 years of age and younger will be reviewed by a psychiatrist.
- Psychiatric admission requests for clients who are 12 through 20 years of age will be reviewed by a mental health professional. Any requests for psychiatric admissions that do not meet the criteria for admission will be referred to a psychiatrist for final determination.
- A completed Psychiatric Inpatient Initial Admission Request Form or Psychiatric Inpatient Extended Stay Request Form prescribing the inpatient psychiatric services must be signed and dated by the admitting physician familiar with the client prior to requesting authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed Psychiatric Inpatient Initial Admission Request Form or Psychiatric Inpatient Extended Stay Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the hospital’s medical record for the client.
- For initial inpatient admissions to freestanding and state psychiatric facilities, the completed Psychiatric Inpatient Initial Admission Request Form must be faxed no later than the date of the client’s admission unless the admission is after 5 p.m., on a holiday or a weekend. When the admission occurs after 5 p.m., on a holiday or a weekend, the CCIP unit must receive the faxed request on the next business day following admission. If the admission occurs after 2 p.m., the provider must contact the CCIP unit by telephone and fax the Psychiatric Inpatient Initial Admission Request Form to the CCIP unit on the following business day.
To complete the prior authorization process, the provider must fax the completed Psychiatric Inpatient Admission Form to the TMHP CCIP prior authorization unit.

Providers must submit a Psychiatric Inpatient Extended Stay Request Form to the TMHP CCIP unit requesting prior authorization for a continuation of stay. Requests for a continuation of stay must be received on or before the last day authorized or denied. The provider is notified of the decision in writing via fax by the CCIP unit. If the date of the CCIP unit determination letter is on or after the last day authorized or denied, the request for continuation of stay is due by 5 p.m. of the next business day.

The Psychiatric Inpatient Extended Stay Request Form must reflect the need for continued stay in relation to the original need for admission. Any change in the client’s diagnosis must be noted on the request. Additional documentation or information supporting the need for continued stay may be attached to the form. Up to seven days may be authorized for an extension request.

**Medicaid Clinical Criteria for the Initial Inpatient Psychiatric Stay**

The client must have a valid AXIS I diagnosis as listed in the current version of the DSM as the principal admitting diagnosis and one of the following:

- Outpatient therapy or partial hospitalization has been attempted and failed
- A psychiatrist has documented reasons why an inpatient level of care is required.
- The client’s Axis II diagnosis must also be included on the request for inpatient psychiatric treatment.
- The client must meet at least one of the following criteria:
  - The client is presently a danger to self, demonstrated by at least one of the following:
    - Recent suicide attempt or active suicidal threats with a deadly plan, and there is an absence of appropriate supervision or structure to prevent suicide.
    - Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting/burning self).
    - Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or retardation resulting in a significant inability to care for self.
  - Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the client. The medical (AXIS III) diagnosis must be treatable in a psychiatric setting.
  - The client is a danger to others. This behavior must be attributable to the client's specific AXIS I diagnosis as listed in the current version of the DSM, and can be adequately treated only in a hospital setting.
    - This danger is demonstrated by one of the following:
      - Recent life-threatening action or active homicidal threats of same with a deadly plan, availability of means to accomplish the plan, and with likelihood of acting on the threat.
      - Recent serious assaultive or sadistic behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent assaultive behavior.
      - Active hallucinations or delusions directing or likely to lead to serious harm of others.
- The client exhibits acute onset of psychosis or severe thought disorganization, or there is significant clinical deterioration in the condition of someone with a chronic psychosis, rendering the client unmanageable and unable to cooperate in treatment, and the client is in need of assessment and treatment in a safe and therapeutic setting.

- The client has a severe eating or substance abuse disorder that requires 24-hour-a-day medical observation, supervision, and intervention.

- The client exhibits severe disorientation to person, place, or time.

- The client’s evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors and other behaviors, which may also include physical, psychological, or sexual abuse.

- The client requires medication therapy or complex diagnostic evaluation where the client’s level of functioning precludes cooperation with the treatment regimen.

- The client is involved in the legal system, manifests psychiatric symptoms, and is ordered by a court to undergo a comprehensive assessment in a hospital setting to clarify diagnosis and treatment needs.

- The proposed treatment or therapy requires 24-hour-a-day medical observation, supervision, and intervention and must include all of the following:
  - Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board (TMB) and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment/therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.
  - Implementation of an individualized treatment plan.
  - Provision of services that can reasonably be expected to improve the client’s condition or prevent further regression so that a lesser level of care can be implemented.
  - Proper treatment of the client’s psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist and is being provided in the least restrictive environment available, and ambulatory care resources available in the community do not meet the client’s needs.

**Medicaid Clinical Criteria for Continued Stays**

Continued stays are considered for THSteps clients in freestanding and state psychiatric hospitals when the client meets at least one of the criteria from above and have a treatment or therapy regimen, which must include all of the following:

- Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board (TMB) and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment/therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.

- Treatment/therapy requires an inpatient level of care.

- Initial discharge plans have been formulated and actions have been taken toward implementation, including documented contact with a local mental health provider.

Continued stays are considered for children and adolescents whose discharge plan does not include returning to their natural home. If the party responsible for placement has provided the provider with three documented placement options for which the child meets admission criteria, but cannot accept the child, up to five days may be authorized, per request, to allow alternative placement to be located. Up to three 5-day extensions may be authorized.
Court-Ordered Services
A request for prior authorization of court-ordered services must be submitted no later than seven calendar days after the date on which the services began.

Court-ordered services are not subject to the five-day admission limitation or the seven-day continued stay limitation. Court-ordered services include:

- Mental health commitments
- Condition of probation (COP)

For court-ordered admissions, a copy of the doctor's certificate and all court-ordered commitment papers signed by the judge must be submitted with the psychiatric hospital inpatient form.

Prior Authorization Appeals
All prior authorization requests not submitted or received by the TMHP CCIP unit in accordance with established policies are denied through the submission date, and claim payment is not made for the dates of service denied.

All denials may be appealed. The TMHP CCIP unit must receive these appeals within 15 days of the TMHP CCIP unit denial notice.

Appeals of a denial for an initial admission and/or a continued stay, must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration.

Appeals of a denial for late submission of information, must be accompanied by documentation that the provider believes supports the compliance with HHSC claims submission guidelines.

Appeals are reviewed first by an experienced psychiatric licensed clinical social worker (LCSW) or a registered nurse (RN) to determine if the required criteria is documented and then forwarded to a psychiatrist for final determination. The provider will be notified of all denial determinations in writing via fax by the TMHP CCIP unit.

3.4.4.2 *Psychiatric Services for Clients 65 Years of Age and Older*
IMD services for clients who are 65 years of age and older must be medically necessary and do not require prior authorization.

3.4.4.3 *Reimbursement for Services Rendered in an IMD*
The following services will not be reimbursed during an inpatient stay when they are rendered to clients who are admitted as inpatients to an IMD:

- Ambulance
- Case management
- Acute care hospital
- Mental health rehabilitation
- School Health and Related Services (SHARS)

IMD providers may be reimbursed only for services that are rendered to clients who are 20 years of age and younger or 65 years of age and older. IMD services and services rendered at an IMD to clients who are 21 years of age through 64 years of age are not eligible for reimbursement.

Services that are rendered in an IMD facility must be identified in the client's plan of care. Services that are not included in the client's plan of care are subject to recoupment.

If the client has not been discharged from the IMD, the IMD provider is responsible for acute care services that are rendered to the client in an acute care facility, and claims that are submitted for these services will be denied as a duplicate service that has been paid to another provider.
Services that are rendered on the date of admission to the IMD and the date of discharge from the IMD may be reimbursed.

**Important:** Claims for professional services rendered during an inpatient stay in an Institution for Mental Disease (IMD) must include the IMD facility's ten-digit National Provider Identifier (NPI). Claims that do not include the IMD Facility's NPI will be denied.

### 3.4.4.3.1 *Medicare Coinsurance and Deductible Reimbursement*

Freestanding psychiatric hospitals that are enrolled in Medicare may also receive Medicaid payment for the Medicare coinsurance and deductible amounts according to Medicaid guidelines.

Exception: IMD services for clients who are 21 through 64 years of age are not benefits of Texas Medicaid. Medicaid will not reimburse coinsurance and deductible payments for psychiatric services that are rendered to these clients in an IMD.

**Refer to:** Subsection 2.7, “Medicare Crossover Claim Reimbursement,” ([Vol. 1, General Information](#)) for additional information about Medicaid guidelines for Medicare coinsurance and deductible payments.

### 3.4.4.4 *Providing IMD Client Information to TMHP*

IMD providers are requested to inform TMHP of the Medicaid clients who are residing in their facilities before submitting inpatient claims for those clients.

IMD providers can use the TMHP secure web page to enter client information and the admission and discharge dates by going to My Account and choosing the Manage IMD Clients Segment link in the Acute Care Online Portal field.

IMD providers can search for Medicaid client records that are associated with their provider identifiers.

Providers will be asked to submit the client’s identification number and admission date. After the client is discharged, providers will be requested to enter the discharge date on the same Manage IMD Clients Segment screen.

Providers will not be able to change previously reported client information except for the To Date of Service information. If providers enter inaccurate information, they must contact HHSC to request a correction to the information. This change request must include appropriate documentation of the client’s patient control number (PCN) and the admission and discharge dates.

### 3.4.5 Medicaid Clinical Criteria for Inpatient Psychiatric Care for Clients*

The client must have a valid AXIS I, DSM-IV-TR diagnosis as the principle admitting diagnosis and outpatient therapy or partial hospitalization has been attempted and failed, or a psychiatrist has documented reasons why an inpatient level of care is required. The client’s Axis II diagnosis must also be included on the request for inpatient psychiatric treatment.

The client must meet at least one of the following criteria:

- The client is presently a danger to self, demonstrated by at least one of the following:
  - Recent suicide attempt or active suicidal threats with a deadly plan and an absence of appropriate supervision or structure to prevent suicide.
  - Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting or burning self).
  - Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or intellectual disability resulting in a significant inability to care for self.
• Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the client. The medical (AXIS III) diagnosis must be treatable in a psychiatric setting.

• The client is a danger to others. This behavior should be attributable to the client’s specific Axis I or DSM-IV-TR diagnosis and can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:
  
  • Recent life-threatening action or active homicidal threats of same with a deadly plan and availability of means to accomplish the plan with likelihood of acting on the threat.
  
  • Recent serious assaultive or sadistic behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent assaultive behavior.
  
  • Active hallucinations or delusions directing or likely to lead to serious harm of others.

• The client exhibits acute onset of psychosis or severe thought disorganization, or there is significant clinical deterioration in the condition of someone with a chronic psychosis, rendering the client unmanageable and unable to cooperate in treatment, and the client is in need of assessment and treatment in a safe and therapeutic setting.

• The client has a severe eating or substance abuse disorder which requires 24-hour-a-day medical observation, supervision, and intervention.

• The client exhibits severe disorientation to person, place, or time.

• The client’s evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors and other behaviors which may also include physical, psychological, or sexual abuse.

• The client requires medication therapy or complex diagnostic evaluation where the client’s level of functioning precludes cooperation with the treatment regimen.

• The client is involved in the legal system, manifests psychiatric symptoms, and is ordered by court to undergo a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs.

The proposed treatment or therapy requires 24-hour-a-day medical observation, supervision, and intervention and must include all of the following:

• Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board (TMB) and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment or therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.

• Implementation of an individualized treatment plan.

• Provision of services which can reasonably be expected to improve the client’s condition or prevent further regression so that a lesser level of care can be implemented.

Proper treatment of the client’s psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist and is being provided in the least restrictive environment available, and ambulatory care resources available in the community do not meet the client’s needs.

### 3.4.6 Continued Stays

Continued stays are considered when the client meets at least one of the criteria from above and has a treatment or therapy regimen that includes all of the following:
• Active supervision by a psychiatrist with the appropriate credentials as determined by the TMB and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment or therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.

• Treatment or therapy requires an inpatient level of care.

• Initial discharge plans have been formulated and actions have been taken toward implementation, including documented contact with a local mental health provider.

Continued stays are considered for children and adolescents whose discharge plan does not include returning to their natural home. If the party responsible for placement has provided the provider with three documented placement options for which the child meets admission criteria, but which cannot accept the child, up to five days may be authorized, per request, to allow alternative placement to be located. Up to three five-day extensions may be authorized.

3.4.7 Court-Ordered Services

A request for prior authorization of court-ordered services must be submitted no later than seven calendar days after the date on which the services began.

Court-ordered services are not subject to the 12-hour system limitation per provider, per day when billed with modifier H9.

Court-ordered services are not subject to the five day admission limitation or the seven day continued stay limitation. Court-ordered services include:

• Mental health commitments
• Condition of probation (COP)

For court-ordered admissions, a copy of the doctor’s certificate and all court-ordered commitment papers signed by the judge must be submitted with the psychiatric hospital inpatient form.

Specific court-ordered services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as mandated by the court. A copy of the court document signed by the judge must accompany prior authorization requests. If the requested services differ from the court order, the additional services will be reviewed for medical necessity. Requested services beyond those court-ordered are subject to medical necessity review.

3.4.8 Denials

All prior authorization requests not submitted or received by the TMHP CCIP Unit in accordance with established policies are denied through the submission date, and claim payment is not made for the dates of service denied.

All denials may be appealed. The TMHP CCIP Unit must receive these appeals within 15 days of the TMHP CCIP Unit denial notice.

• Appeals of a denial for an initial admission or a continued stay must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration.

• Appeals of a denial for late submission of information must be accompanied by documentation which the provider believes supports the compliance with HHSC claims submission guidelines.

• Appeals are reviewed first by an experienced psychiatric LCSW (Licensed Clinical Social Worker) or an RN to determine if the required criteria is documented and then forwarded to a psychiatrist for final determination. The provider will be notified of all denial determinations in writing via fax by the TMHP CCIP Unit.
3.5 * Inpatient Utilization Review

UR activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 are required by Title XIX of the Social Security Act, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to UR monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of Texas Medicaid.

The HHSC Office of Inspector General (OIG) UR Unit is responsible for retrospective review of inpatient DRG and TEFRA admissions. These reviews are accomplished through onsite visits, electronic access, or mail-in.

3.5.1 * Utilization Review Process

The inpatient UR process for admissions reimbursed under the DRG prospective payment system consists of sampling medical records of paid Medicaid claims. The review process consists of three major components:

- **Admission review.** Determination of the medical necessity of the admission. For purposes of the Texas Medical Review Program (TMRP) and TEFRA, medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.

- **Quality review.** Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.

- **DRG validation.** Determination that the critical elements necessary to assign a DRG are present in the medical record and the diagnosis and procedures are sequenced correctly. The critical elements are age, sex, admission date, discharge date, patient discharge status, principal diagnosis, secondary diagnoses (complications or comorbidities), and principal and secondary procedures.

The HHSC OIG UR Unit staff reviews the complete medical record to make decisions about the medical necessity of the admission, validity of the DRG, and quality of care. The medical record must reflect that any services reimbursed by Texas Medicaid were ordered by a physician, certified nurse-midwife (CNM), or nurse practitioner (NP).

Effective for dates of admission on or after September 1, 2006, the HHSC OIG UR Unit uses evidence-based guidelines to assist in performing retrospective UR of inpatient hospital claims for Medicaid clients. The evidence-based guidelines are Milliman Care Guidelines, which replace the physician-developed and physician-approved Medicaid hospital screening criteria addressed through a rule revision effective August 1, 2006. Reviews required by the TMRP, TEFRA, and the TMHP Comprehensive Inpatient Psychiatric Unit (CCIP) contracting program are included.

All services, supplies, or items submitted are medically necessary for the client’s diagnosis or treatment as certified on claim submission.

Refer to: Subsection 1.5.8, “Provider Certification/Assignment,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

When an admission denial or a denial of continued stay is issued, or when a technical denial becomes final, all money is recouped from the hospital for the admission or days of stay that are denied. When a DRG is reassigned as a result of UR, the payment to the hospital is adjusted.
If an inpatient admission is denied, but a physician’s order is present documenting the client originally was placed in observation, the UR unit may authorize the resubmission of services rendered during the first 48 hours on an outpatient claim.

### 3.5.1.1 Admission Review

Effective for admissions on or after September 1, 2006, review personnel assess the medical necessity of an admission by comparing documentation present in the medical record using recognized evidence-based guidelines for inpatient screening criteria. Non-physician reviewers use the criteria as guidelines for the initial approval or for the referral of inpatient reviews for medical necessity decisions. Cases that do not meet initial approval are referred to a physician consultant to determine the medical necessity of the inpatient admission. If the criteria are met but the medical necessity of the admission is still questionable, the case is referred to a physician consultant for a determination. If a physician consultant determines the admission is not medically necessary, a denial is issued.

Review personnel assess the medical necessity of admissions prior to September 1, 2006, by comparing documentation present in the medical record with elements in the TMRP Hospitalization Screening Criteria. For an admission to be approved, an indication for hospitalization and treatment criteria must be met. Cases that do not meet both screening criteria are referred to a physician consultant to determine the medical necessity of the inpatient admission. If the TMRP Hospitalization Screening Criteria are met but the medical necessity of the admission is still questionable, the case is referred to a physician consultant for a determination. If a physician consultant determines the admission is not medically necessary, a denial is issued.

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action such as recoupment or referral to HHSC OIG Medicaid Program Integrity (MPI) or Sanctions Unit.

### 3.5.1.2 Readmission Review

If a hospital admission or readmission occurs within 30 days of a discharge from the same or a different hospital for the same or closely related diagnosis, or for a condition identified during the previous admission, it may be reviewed for medical necessity.

Transfers from one facility to another and readmissions are also subject to review.

### 3.5.1.3 Hospital-Based Ambulatory (HASC) Surgical Procedures

Inpatient admissions for surgical procedures listed as ambulatory surgical codes in the current fee schedule are denied if documentation does not support the need for the inpatient admission.

### 3.5.1.4 Quality Review

Each Medicaid case is evaluated for quality of client care, adequacy of discharge planning, and medical stability of the client at discharge. To accomplish this review, CMS Generic Quality Screens and discharge screens included in the TMRP Hospitalization Screening Criteria are used. Potential quality of care issues are identified by the physician. HHSC contracts with physician consultants to review medical records for quality of care. Physician consultants, of the specialty related to the care rendered, may make clinical recommendations or determine corrective actions when deemed appropriate. Child and adolescent psychiatrists may make recommendations based on review of inpatient psychiatric services provided to Medicaid clients younger than 21 years of age. Failure to verify completion of any corrective action recommendation within the specified time frame may result in referral of the case to the HHSC OIG MPI or Sanctions Unit.
3.5.1.5 * Diagnosis-Related Group Validation

Each medical record is reviewed to validate the elements critical to the DRG assignment. These elements are the client’s age, sex, admission date, patient discharge date, patient discharge status, principal diagnosis, secondary diagnoses (complications or co-morbidities), and principal and secondary procedures. Documentation of these critical DRG elements in the medical record is evaluated for the correlation to the information provided on the claim form.

The principal diagnosis is the diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The condition must be treated or evaluated during this admission to the hospital.

The secondary diagnoses are conditions that affect client care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and monitoring, or have clinically significant implications for future health-care needs.

The coding of diagnoses that have clinically significant implications for future health-care needs applies only to newborns and must be identified by the physician. Normal newborn conditions or routine procedures are not to be considered as complications or co-morbidities for DRG assignment.

Refer to: Subsection 1.9, “Texas Medicaid Limitations and Exclusions,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

If the principal diagnosis, secondary diagnoses (complications or co-morbidities), or procedures are not substantiated in the medical record; sequenced correctly; or have been omitted, codes may be deleted, changed, or added. All diagnosis/procedure coding changes potentially resulting in a DRG change are referred to a physician consultant. When it is determined that the diagnoses and procedures are substantiated and sequenced correctly, the information will be entered into the applicable version of the Grouper software for a DRG determination. The CMS-approved DRG software considers each diagnosis and procedure and the combination of all codes and elements to make a determination of the final DRG assignment. When the DRG is reassigned, the payment to the provider is adjusted.

3.5.2 * Recommendations to Enhance Compliance with Texas Medicaid Fee-for-Service Hospital Claims Submission

The following information highlights an area for physician and hospital providers where collaboration in client care delivery exists but can improve. Texas Medicaid, through its hospital UR activities, has identified this area for both compliance with provider responsibilities and the reduction of the submission of inappropriate inpatient hospital claims.

To enhance compliance with Texas Medicaid fee-for-service hospital claims submission and decrease the submission of inappropriate inpatient hospital claims, providers should adhere to the following:

• For admissions on or after September 1, 2006, physicians and hospital staff should become familiar with the Milliman Care Guidelines for medical necessity for inpatient admission.

• The hospital may admit clients in observation status if the physician has the reasonable expectation that the client will be discharged within 48 hours. If an inpatient claim was denied per retrospective UR, the hospital may resubmit the claim for the first 48 hours as an outpatient claim if the client was initially admitted in observation status (per physician order) and the stay was more than 48 hours.

• When a client is admitted to the hospital as an inpatient and is discharged in less than 48 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status.

• This practice is acceptable when the physician makes changes to the admitting order before the hospital submits the claim for payment.

• This correction in admission status avoids errors in claims submission and the potential need for a more lengthy appeal process.
• If the physician admitting orders do not accurately reflect the services provided, the hospital inpatient claim may be denied and the inappropriate payment recovered from both the hospital and the admitting physician.

3.5.3 Hospitals Reimbursed Under Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982

For all Medicaid admissions identified for review, the TEFRA review process consists of the following major components:

• Admission review. Determination of the medical necessity of the admission. For purposes of the TMRP and TEFRA, medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.

• Continued stay review. Determination of the medical necessity of each day of stay.

• Quality of care review. Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.

TEFRA hospitals are required to submit all charges.

HHSC OIG UR Unit staff review the complete medical record to make decisions about the medical necessity of the admission, continued stay, and quality of care.

3.5.4 Technical Denials (DRG Prospective Payment and TEFRA)

3.5.4.1 * On-Site Reviews

The following information describes on-site reviews:

• If the complete medical record is not made available during the on site review, a preliminary technical denial is issued on site. The hospital is allowed 60 calendar days from the date of the exit conference to provide the complete medical record to HHSC. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

• If a complete medical record is made available on site, but a copy is required for further review, and the copy is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

  Note: A notarized business record affidavit in the format approved by HHSC is required for paper and electronic copies of requested medical records. A provider failing to provide this documentation must resubmit the requested records with the affidavit.

Refer to: Subsection 1.5.3, “Retention of Records and Access to Records and Premises,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

3.5.4.2 Mail-In Reviews

If the complete medical record is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.
Hospital inpatient claim payments that have been recouped because of a technical denial may not be resubmitted on an outpatient claim.

**Note:** A notarized business record affidavit in the format approved by HHSC is required for paper and electronic copies of requested medical records. A provider who fails to provide this documentation must resubmit the requested records with the affidavit.

**Refer to:** Subsection 1.5.3, “Retention of Records and Access to Records and Premises,” in Section 1, “Provider Enrollment and Responsibilities” (*Vol. 1, General Information*).

### 3.5.5 Acknowledgment of Penalty Notice

Hospitals must have on file a signed acknowledgment from the physician stating that the physician received the following notice:

**Notice to Physicians:** Medicaid payment to hospitals is based, in part, on each client’s principal and secondary diagnoses and the major procedures performed on the client, as attested to by the client’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal or state funds, may be subject to fine, imprisonment, or civil penalty under applicable federal and state laws.

The acknowledgment of penalty notice must be specific to Texas Medicaid. Medicare penalty notices are not accepted.

### 3.5.6 Sanctions

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action such as recoupment or referral to HHSC OIG MPI or Sanctions Unit.

### 3.5.7 Utilization Review Appeals

Hospital providers may appeal adverse decisions by HHSC OIG UR Unit to the HHSC UR Medical Appeals Unit. A UR Medical Appeals decision is the final administrative decision of HHSC. Neither HHSC OIG UR Unit nor TMHP are responsible for Medical UR appeals.

**Refer to:** Subsection 7.3.3, “Utilization Review Appeals,” in Section 7, “Appeals” (*Vol. 1, General Information*).

### 3.6 Claims Filing and Reimbursement

#### 3.6.1 Medicaid Relationship to Medicare

Texas Medicaid makes coinsurance and deductible payments on valid, assigned Part A (hospital) and Part B (medical) Medicare claims.

**Exception:** If the Medicare payment amount equals or exceeds the Medicaid payment rate, HHSC is not required to pay the Medicare Part A deductible/coinsurance/copay on a crossover claim.

Texas Medicaid provides reimbursement for 30 inpatient benefit days per spell of illness. When the 30 days coincide with the first 30 days of the Medicare benefit period and the client is eligible for both Medicare and Medicaid, Texas Medicaid pays the:

- Inpatient hospital deductible under Medicare Part A.
- Medicare Part A deductible for the first three pints of whole blood or packed red cells.

When the client only has Medicare Part B coverage, the hospital must follow these guidelines:

- Submit to Medicare the charges for certain inpatient ancillary services on a Medicare Claim Form 1483 for payment under the client’s Part B coverage. The ancillary charges include the following:
  - Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests.
• X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
• Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations
• Prosthetic devices (other than dental) that replace all or part of an internal body organ or member (including contiguous tissue) or all or part of the function of a permanently inoperative or malfunctioning internal body organ or member including replacement or repairs of such devices (e.g., cardiac pacemakers, breast prostheses, maxillofacial devices, colostomy bags, and prosthetic lenses)
• Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements and adjustments (if required) because of a change in the client’s physical condition
• Physical therapy (PT) services
• Speech pathology services
• Dialysis treatments

• Submit to TMHP the remaining Part A charges on a UB-04 CMS-1450 paper claim form (or its electronic equivalent) indicating in Block 80 that the client is eligible for Medicare Part B benefits only. The client’s health insurance claim (HIC) number must appear on the Medicaid claim in Block 80. TMHP must receive these charges within 95 days of the last date of service on the claim.

Refer to: Subsection 2.6, “Medicare Crossover Claim Reimbursement,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

3.6.2 * Inpatient Claims Information

Medicaid present on admission (POA) reporting is required for all inpatient hospital claims paid under prospective payment methodology.

All hospital providers are required to submit a POA value for each diagnosis on the claim form, and no hospital is exempt from this POA requirement. Medicare crossover hospital claims must also comply with the Medicaid requirement to include the POA values.

POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient visit, including emergency department, observation, or outpatient surgery, are considered POA.

Claims submitted without POA will be denied unless the facility or the diagnosis code is exempt from POA reporting.

The following table shows the POA values.

<table>
<thead>
<tr>
<th>POA Value</th>
<th>Description</th>
<th>Payment</th>
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<tr>
<td>Y</td>
<td>Diagnosis was present at the time of admission</td>
<td>Payment will be made by Medicaid when a hospital-acquired condition (HAC) is present</td>
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<tr>
<td>N</td>
<td>Diagnosis was not present at the time of admission</td>
<td>No payment will be made by Medicaid when an HAC is present</td>
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<td>U</td>
<td>Documentation was insufficient</td>
<td>No payment will be made by Medicaid when an HAC is present</td>
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<td>W</td>
<td>Clinically undetermined</td>
<td>Payment will be made by Medicaid when an HAC is present</td>
</tr>
<tr>
<td>J</td>
<td>Exempt from POA reporting</td>
<td>Exempt from POA reporting</td>
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</table>
TMHP will not recalculate the DRG based on POA indicator values for Medicare crossover claims or MCOs.

Depending on the POA indicator value, the DRG may be recalculated, resulting in a lower payment to the hospital facility provider. If the number of days on an authorization is higher than the number of days allowed as a result of a POA DRG recalculation, the lesser of the number of days will be reimbursed.

The following table includes the additional diagnosis codes that are exempt from POA reporting effective for claims with dates of service on or after October 1, 2010:

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## Diagnosis Codes

Claims for inpatient hospital services must be submitted to TMHP in an approved electronic format or on the 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 attachments. Superbills, or itemized statements, are not accepted as claim supplements.

In Block 44 of the UB-04 CMS-1450, enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim.

Hospitals may submit information only claims to TMHP when one of the following situations exists. Hospitals must use TOB 110 to file these claims:

- Inpatient 30-day spell of illness benefit is exhausted.
- Payment made by a third party resource or other insurance exceeds the Medicaid allowed amount.

Additional claims information can be found within individual topic areas in this section.

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

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


### 3.6.3 Inpatient Reimbursement

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.

#### 3.6.3.1 Prospective Payment Methodology

Inpatient hospital stays except in children’s hospitals, state-owned teaching hospitals, and psychiatric facilities (CCP) are reimbursed according to a prospective payment methodology based on diagnosis-related groups (DRGs). The reimbursement method itself does not affect inpatient benefits and limitations. Inpatient admissions must be medically necessary and are subject to Texas Medicaid’s UR requirements.

The DRG reimbursement includes all facility charges (e.g., laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. The technical services are not billable to Texas Medicaid clients.

Texas Medicaid does not distinguish types of beds or units within the same acute care facility for the same inpatient stay (e.g., psychiatric or rehabilitation). Because all Medicaid inpatient hospitalizations are included in the DRG database that determines the DRG payment schedule, psychiatric and rehabili-
itation admissions are not excluded from the DRG payment methodology. To ensure accurate payment, Texas Medicaid requires that only one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing. The discharge and admission hours (military time) are required on the UB-04 CMS-1450 paper claim form, to be considered for payment.

The number of days of care charged to a beneficiary for inpatient hospital or skilled nursing facility (SNF) care services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for reporting purposes even if the hospital or SNF uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission and day on which a patient returns from leave of absence, counts as a full day. However, the day of discharge, death, or a day on which a patient begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission.

If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims may be subject to retrospective review, which may result in recoupment. This limitation does not apply to services related to certain organ transplants or services to THSteps clients when provided through CCP.

In accordance with legislative direction included in the 2006–2007 General Appropriations Act (Article II, Section 49, S.B. 1, 79th Legislature, Regular Session, 2005), a rate reduction will be applied to inpatient hospital services rendered to non-Medicare Supplemental Security Income (SSI) and SSI-related Medicaid clients. The rate reduction will affect hospital providers within the Bexar, Dallas, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis service areas that are reimbursed by DRG.

Effective September 1, 2007, a hospital that is either located in a county with 50,000 or fewer persons, is a Medicare-designated rural referral center (RRC) or sole community hospital (SCH) that is not located in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget, or is a Medicare-designated CAH, will be reimbursed the greater of the prospective payment system rate or a cost-reimbursement methodology authorized by TEFRA using the most recent data.

A new provider is given a reimbursement inpatient interim rate of 50 percent until a cost audit has been performed. A default standard dollar amount (SDA) rate is assigned for newly enrolled providers or newly constructed facilities.

Payment is calculated by multiplying the SDA for the hospital’s payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Hospital reimbursement is made in accordance with the following TAC rules:

- **1 TAC §355.8052 - Inpatient Hospital Reimbursement**
- **1 TAC §355.8054 - Children’s Hospital Reimbursement Methodology**
- **1 TAC §355.8056 - State-Owned Teaching Hospital Reimbursement Methodology**
- **1 TAC §355.8058 - Inpatient Direct Graduate Medical Education (GME) Reimbursement**
- **1 TAC §355.8060 - Reimbursement Methodology for Freestanding Psychiatric Facilities**
- **1 TAC §355.8061 - Payment for Hospital Services**
- **1 TAC §355.8064 - Reimbursement Adjustment for Hospitals Providing Inpatient Services to SSI and SSI-Related Clients**
- **1 TAC §355.8065 - Disproportionate Share Hospital (DSH) Reimbursement Methodology**
- **1 TAC §355.8068 - Supplemental Payments to Certain Urban Hospitals**
- **1 TAC §355.8069 - Supplemental Payments to Certain Rural Public Hospitals**
Medicaid providers that are cost-reimbursed are subject to cost reporting, cost reconciliation, and cost settlement processes, as defined in the following TAC rules:

- 1 TAC §355.8061 (a)(2) - Outpatient Payment for Hospital Services
- 1 TAC §355.8052 (i) - Hospitals in counties with 50,000 or fewer persons and certain other hospitals.
- 1 TAC §355.8070 - Supplemental Payments to Private Hospitals
- 1 TAC §355.8071 - Supplemental Payments to Children’s Hospitals
- 1 TAC §355.8072 - Supplemental Payments to State-Owned Hospitals
- 1 TAC §355.8054 - Children’s Hospital Reimbursement Methodology
- 1 TAC §355.8056 - State-Owned Teaching Hospital Reimbursement Methodology

3.6.3.2 Client Transfers

3.6.3.2.1 Admission Dates

To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date on which the client was admitted into each facility in Block 12 on the UB-04 CMS-1450.

3.6.3.2.2 Continuous Stays – Client Transfers and Readmissions

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. Texas Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be submitted as one admission under the provider identifier. Readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are also considered one continuous stay and receive only one DRG payment.

Readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Admissions submitted inappropriately are identified and denied during the UR process and may result in intensified review.

When more than one hospital provides care for the same client, the hospital providing the most significant amount of care receives consideration for a full DRG payment. The other hospitals are paid a per diem rate based on the lesser of either the mean length of stay for the DRG or the eligible days in the facility. The DRG modifier, PT, on the R&S Report indicated per diem pricing related to a client transfer. Services must be medically necessary and are subject to Texas Medicaid’s UR requirements.

HHSC performs a postpayment review to determine if the hospital providing the most significant amount of care received the full DRG. If the review reveals that the hospital providing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date that the client was admitted into each facility in Block 12 on the UB-04 CMS-1450. Inpatient authorization requirements are based on the requirements that are specified by the program in which the client is enrolled on the date of the original admission. Providers must adhere to the authorization requirements for claims to be considered for reimbursement. Providers are reimbursed at the rate in effect on the date of admission.

3.6.3.3 Observation Status to Inpatient Admission

When a client’s status changes from observation to inpatient admission, the date of the inpatient admission is the date the client was placed on observation status. This rule always applies regardless of the length of time the client was in observation (less than 48 hours) or whether the date of inpatient admission is the following day. All charges including the observation room are submitted on the inpatient claim (TOB 111).
3.6.3.4 Outliers

TMHP makes outlier payment adjustments to DRG hospitals for admissions that meet the criteria for exceptionally high costs or exceptionally long lengths of stay for clients who are 20 years of age and younger as of the date of the inpatient admission. If a client’s admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid.

Providers can view their day and cost outlier payment information for inpatient hospital claims on the Electronic Remittance and Status (ER&S) Report. The R&S Report reflects the outlier reimbursement payment and defines the type of outlier paid. To view the day and cost outlier payment information, providers, facilities, and third party vendors may need to update their 835 electronic file format. For information about how to update the 835 electronic file format, refer to the revised electronic data interchange (EDI) companion guide (ANSI ASC X12N 835 Healthcare Claim Payment/Advice-Acute Care Companion Guide) on the TMHP website at www.tmhp.com.

3.6.3.4.1 Day Outliers

Effective September 1, 2011, the following criteria must be met to qualify for a day outlier payment:

- Inpatient days must exceed the DRG day threshold for the specific DRG.
- Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 60 percent of the per diem amount of a full DRG payment.
- The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

Hospitals must use the following formula to calculate the day outliers. To calculate the day outlier payment amount, the number of outlier days must first be determined:

\[
\text{Number of Days Allowed - DRGs Threshold} = \text{Outlier Days}
\]

\[
\frac{\text{SDA} \times \text{DRG relative weight}}{\text{Mean length of stay}} \times \text{Outlier Days} \times 0.60 = \text{Day outlier amount}
\]

3.6.3.4.2 Cost Outliers

To establish a cost outlier, TMHP determines the outlier threshold by using the full DRG payment amount multiplied by 1.5 or an amount determined by selecting the lesser of the universal mean of the current base year data multiplied by 11.14 or the hospital’s SDA multiplied by 11.14. The calculation that yields the greater amount is used in calculating the actual cost outlier payment. Effective September 1, 2011, the outlier threshold is subtracted from the amount of reimbursement for the admission established under TEFRA principles, and the remainder multiplied by 60 percent to determine the actual amount of the cost outlier payment.

Hospitals must use the following formulas to calculate the day outliers. Effective for claims with dates of admission on or after September 1, 2011, the Universal Mean is $6,505.62.

To calculate the cost outlier amount, the cost threshold must first be determined. Three calculations and two comparisons are necessary:

\[
11.14 \times \text{Universal Mean ($6,505.62.)} =
\]

1) \[11.14 \times \text{SDA} = \text{Comparison 1: Take lesser of A or B.}\]
2) \[1.5 \times \text{DRG Relative Weight} \times \text{SDA} = \text{Comparison 2: Greater of number C and comparison 1 is the cost threshold.}\]
3) \[\text{Allowed amount x reimbursement rate} = \text{TEFRA amount}\]
4) \[\text{TEFRA amount - comparison 2 (cost threshold) x 60 percent} = \text{cost outlier amount}\]
3.6.3.5 **Children’s Hospitals**

Inpatient hospital stays in designated children’s hospitals are reimbursed according to the TEFRA reimbursement principles on a reasonable cost basis. Designated children’s hospitals are reimbursed on a percentage of the hospital’s standard charges derived from the hospital’s most recent tentative or final Medicaid cost report settlement.

To be designated as a children’s hospital, the hospital must have a provider agreement with Medicare and be engaged in delivering services to patients who are predominantly younger than 18 years of age. A designated children’s hospital is excluded from the Medicare/Medicaid prospective payment system per 42 Code of Federal Regulations (CFR) (Subsection) 412.23.

*Note:* Children’s hospitals that are reimbursed according to the TEFRA methodology may submit interim claims before discharge and must submit an interim claim if the client remains in the hospital past the hospital’s fiscal year end.

3.6.3.6 *Potentially Preventable Complications (PPC) and Potentially Preventable Readmissions (PPR)*

**Potentially Preventable Complications (PPCs)**

By definition, potentially preventable complications (PPCs) are harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than from the natural progression of the underlying illness. A PPC is an inpatient hospital complication that was potentially preventable based on criteria such as hospital characteristics, reason for admission, procedures, and the interrelationships between underlying medical conditions.

S.B. 7, Chapter 526, the 82nd Texas Legislature, 2011, establishes the authority of HHSC to identify PPCs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care providers.

HHSC also produces a public version of the report, which does not specifically identify any of the hospitals. A statewide average PPC rate is calculated for all hospitals within Texas. Each hospital has an individual rate. Hospitals are able to compare their rate of PPC to the statewide average.

**PPC Analysis**

The PPC analysis identifies the presence of a PPC during an inpatient stay. The presence of a PPC only affects payment if it causes the stay to group a different DRG. PPCs can be influenced by the severity of an illness, age of a patient, base All Patient Refined Diagnosis Related Group (APR-DRG), and serious mental illness or substance abuse co-morbidity.

The PPC analysis includes the entire Medicaid population, with the following exceptions:

- Newborns and pediatrics- The 3M™ PPC software was not designed to evaluate newborn and pediatric stays.
- Dual eligibles- Stays for patients who are eligible for both Medicare and Medicaid are excluded if Medicare is the primary payer for the stay. These are excluded from the base Blue Ribbon file used for the PPC analysis.

The PPC analysis uses the annual INRR520A Blue Ribbon File to compile inpatient claims data for Medicaid fee-for-service (FFS) and Primary Care Case Management (PCCM). Managed care encounter data is not included in the state fiscal year 2011 PPC report because they were not required to report Present on Admission (POA) values until December 2011. Managed care encounter data will be included in the November 2012 PPC report and subsequent reports. CSHCN claims are excluded from PPC analyses.

The PPC analysis is performed using 3M™ Core Grouping software, which re-assigns APR-DRGs to each admission and calculates the PPC rates for each hospital. Hospitals that are enrolled as fee-for-service are identified by their Texas Provider Identifier (TPI).
The PPC approach is to calculate hospital-wide rates of potentially preventable complications, adjust these rates for differences in case-mix among patients and among hospitals, and compare these case-mix adjusted rates across hospitals relative to a benchmark.

**Potentially Preventable Re-admission (PPRs)**

By definition, potentially preventable re-admissions (PPRs) are return hospitalizations of a person within a period specified by HHSC that results from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up.

Texas Medicaid uses a 15 day re-admission interval.

Section 531.913, House Bill (H.B.) 1218, 81st Legislature, 2009, requires the HHSC to identify PPRs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care providers.

HHSC delivers an annual, confidential report of the results to each hospital that is enrolled in Texas Medicaid, and each of those hospitals must distribute the information to their care providers. HHSC also produces a public version of the report, which does not specifically identify any of the hospitals. Patients are never identified in the reports.

**PPR Analysis**

The PPR analysis includes almost all medical conditions, but only finds a PPR when a plausible clinical connection exists between the initial admission and the re-admission. PPRs can be influenced by the severity of an illness, age of a patient, base APR-DRG, and serious mental illness or substance abuse comorbidity.

The PPR analysis includes the entire Medicaid population with the following exceptions:

- **Newborns**- The 3M™ PPR software was not designed to evaluate newborn stays.
- **Undocumented aliens**- Stays for patients who are undocumented aliens are excluded because they are only eligible for emergency Medicaid.
- **Dual eligibles**- Stays for patients who are eligible for both Medicare and Medicaid are excluded if Medicare is the primary payer for the stay.

The PPR analysis uses the annual INR520A Blue Ribbon file to compile inpatient claims data for Medicaid FFS, Medicaid managed care, Family Planning (FP) Title XIX, and managed care encounters. Children with Special Health Care Needs (CSHCN) claims are excluded from PPR analyses.

The PPR analysis is performed using 3M™ Core Grouping software, which calculates the PPR rates for each hospital and re-assigns APR-DRGs to each admission.

- Hospitals that are enrolled as fee-for-service are identified by their TPI.
- Encounter claims are identified by their NPI. The NPIs are crosswalked to TPIs using the bill types, addresses, and taxonomy codes in the TMHP master provider file.
- For certain stays, the NPI cannot be crosswalked to a TPI with a high degree of confidence, the stays are excluded from the PPR analysis.

**3.6.3.7 State-owned Teaching Hospitals**

Inpatient hospital stays in designated state-owned teaching hospitals are reimbursed according to the TEFRA reimbursement principles on a reasonable cost basis. Designated state-owned teaching hospitals are reimbursed on a percentage of the hospital’s standard charges derived from the hospital’s most recent tentative or final Medicaid cost report settlement.
State-owned teaching hospitals are defined specifically in 1 TAC §355.8052 as the following hospitals: University of Texas Medical Branch (UTMB); University of Texas Health Center Tyler; and M.D. Anderson Hospital. A designated children’s hospital is excluded from the Medicaid prospective payment system.

**Note:** State-owned teaching hospitals that are reimbursed according to the TEFRA methodology may submit interim claims before discharge and must submit an interim claim if the client remains in the hospital past the hospital’s fiscal year end.

### 3.6.3.8 Payment Window Reimbursement Guidelines

#### Guidelines for Services Preceding an Inpatient Admission

The following payment window reimbursement guidelines apply to services that are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

Texas Medicaid inpatient hospital providers must submit, as part of the client’s inpatient hospital claim, all related professional and outpatient services that were rendered on the date of the client’s inpatient admission or one of the following dates immediately before admission:

- Within three calendar days before the client’s inpatient admission for hospitals that receive diagnosis related group (DRG) reimbursement
- Within one calendar day before the client’s inpatient admission for hospitals that receive reimbursement other than DRG.

Professional and outpatient services that must be submitted as part of the inpatient hospital claim include the following services if they are rendered by the hospital or an entity that is wholly owned or operated by the hospital:

- **Diagnostic services.** Diagnostic services include outpatient laboratory and radiology services that are related to the inpatient admission and submitted by physician and outpatient hospital providers. Affected services will include the total and technical components. The professional interpretation component will not be included in the payment windows identified above.
- **Non-diagnostic services.** Non-diagnostic services include surgeries and other non-diagnostic procedures and services that are related to the inpatient admission and submitted by physician, outpatient hospital, or other providers.

**Important:** Related professional and outpatient services that were rendered within the specified time frames must be submitted on the inpatient hospital claim and not on an outpatient hospital claim. An outpatient hospital claim for these services will be denied as part of the payment for the inpatient hospital stay.

#### 3.6.3.8.1 Exceptions

The following services are excluded from the payment window and may be submitted and reimbursed separately from the inpatient admission:

- Services rendered by federally qualified health center (FQHC) providers
- Services rendered by rural health center (RHC) providers
- Professional services that are rendered in the inpatient hospital setting (place of service 3)
- Non-emergency and emergency ambulance services

The outpatient emergency and maintenance renal dialysis procedure codes in the tables below are also exceptions to the one-day payment window reimbursement guidelines:

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<th>Procedure Codes</th>
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3.6.3.8.2 Professional and Outpatient Claims for Services Related to the Inpatient Admission

Professional and outpatient services that are rendered on the date of admission, or within one of the one-day or three-day timeframes indicated above by the hospital or an entity that is wholly owned or operated by the hospital, are considered part of the inpatient stay. Professional and outpatient claims submitted for services that are related to the inpatient admission will be denied or recouped if they are submitted with the specified payment window.

When modifier PD is appended to a professional or outpatient service, the modifier indicates that the service is related to the inpatient admission. The total and technical components for professional and outpatient services that are related to the inpatient admission will be denied when submitted with modifier PD.

**Note:** The professional interpretation component for professional and outpatient services that are related to the inpatient stay may be reimbursed separately even if accompanied by PD modifier.

3.6.3.8.3 Professional and Outpatient Claims for Services Unrelated to the Inpatient Admission

Professional and outpatient services that are rendered within the specified timeframe by the hospital or an entity that is wholly owned or operated by the hospital may be reimbursed if they are identified as unrelated to the inpatient admission as follows:

- Professional and outpatient claims for diagnostic services that are unrelated to the inpatient admission must be submitted with modifier U4, which indicates the service is unrelated to the inpatient admission.

- Professional claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the professional claim to the principal inpatient diagnosis. Professional services must be submitted with modifier U4 if the services are unrelated and the referenced professional diagnosis is a three-digit match to the principal inpatient diagnosis.
• Outpatient claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the outpatient claim to the principal inpatient diagnosis. The outpatient services must be submitted with condition code 51 if the services are unrelated and the referenced outpatient diagnosis is a three-digit match to the principal inpatient diagnosis.

Unrelated services that are denied as part of the inpatient admission can be appealed with modifier U4 or condition code 51, which indicates that the service is unrelated to the inpatient admission.

Note: Claims that are submitted with modifier U4 or condition code 51 will be subject to retrospective review and may be recouped if there is not sufficient documentation to indicate the service was unrelated to the inpatient admission.

These benefit changes do not impact services rendered by providers that are not wholly owned or operated by the hospital.

3.6.3.9 Potentially Preventable Readmissions (PPR)

H.B. 1218, 81st Legislature, Regular Session 2009, requires that HHSC identify potentially preventable readmissions (PPRs) in the Medicaid population and report results confidentially to each hospital. The law also requires each hospital to distribute the information to its care providers.

Refer to: The TMHP Hospital Initiatives web page at www.tmhp.com/Pages/Medicaid/Hospital_PPR.aspx for the new state fiscal year confidential Hospital Specific PPR Report, which includes frequently asked questions (FAQs) that help providers interpret their confidential reports.

3.6.4 Provider Cost and Reporting

The method of determining reasonable cost is similar to that used by Title XVIII (Medicare). Hospitals must include inpatient and outpatient costs in the cost reports submitted annually. The provider must prepare one copy of the applicable CMS Cost Report Form along with the required PCCM supplemental worksheets. The PCCM supplemental worksheets include the Inpatient PCCM D-4 worksheet, available from CMS, and the Outpatient PCCM D, Part V worksheet. A sample of the Outpatient PCCM D, Part V is available on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2.2, “Cost Reimbursement,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

If a change of ownership or provider termination occurs, the cost report is due within five months after the date of the change in ownership or termination. Any request for an extension of time to file must be made on or before the cost report due date and sent to TMHP Medicaid Audit at the address indicated under “Written Communication With TMHP” in the “TMHP Telephone and Address Guide” (Vol. 1, General Information). For questions or assistance, call TMHP Medicaid Audit at (512) 514-3648.

Annual cost reports must be filed as follows:

• Submit one copy of the cost report to TMHP Medicaid Audit within five months of the end of the hospital’s fiscal year along with any amount due to Texas Medicaid.

• TMHP Medicaid Audit performs a desk review of the cost report and makes a tentative settlement with the hospital. A tentative settlement letter requests payment for any balance due to Texas Medicaid or instructs TMHP to pay the amount due to the provider. Interim payment rates are changed at this time based on the cost report.

• Field audits are conducted when necessary.

• Medicaid final settlement is made after a copy of all the following information is received from the provider or the Medicare intermediary. The provider must send TMHP a copy of one of the following:
• Audited or settled without audit Medicare Cost Report
• Medicare Notice of Amount of Program Reimbursement
• Medicare Audit Adjustment Report, if applicable

Medicaid hospitals may request copies of their claim summaries for their cost reporting fiscal year. The summaries for tentative settlements include three additional months of claim payments for the fiscal year. The summaries for final settlements include ten months of claim payments for the fiscal year. TMHP Medicaid Audit uses this data to determine the tentative and final settlements and interim rates.

The Medicaid claim summary data are only generated once each month, and the logs are received by the 15th of the following month. Requests for tentative settlement logs are submitted within 30 days after the fiscal year-end. Final settlement log requests are submitted within nine months after the fiscal year-end.

The Medicaid logs can be requested through the provider’s administrator account on the TMHP website at www.tmhp.com. Medicaid logs can also be requested by calling (512) 506-6117 or by sending a written request to the following address:

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

Allow 45 days for receipt of these logs.

3.6.5 Third Party Liability
Hospitals and providers enrolled in Texas Medicaid are required to inform TMHP about circumstances that may result in third party liability for health-care claims. After receiving this information, TMHP pursues reimbursement from responsible third parties.

Hospitals and providers must mail or fax the Other Insurance Form for Health Insurance or the Tort Response Form for accidents to the following address:

Texas Medicaid & Healthcare Partnership
TPL Correspondence
Third Party Liability Unit PO Box 202948
Austin, TX 78720-2948
Fax: (512) 514-4225


4. OUTPATIENT HOSPITAL (MEDICAL AND SURGICAL ACUTE CARE OUTPATIENT FACILITY)
This section contains benefit, limitation, authorization, and claims filing information for outpatient hospital facility emergency, observation, and other services.

Refer to: “Section 6: Claims Filing” and Section 7: Appeals (Vol. 1, General Information) for more comprehensive information about claims filing and appeals.
Hospital providers are encouraged to review the other handbooks for applicable information, prior authorization requirements, and for specific requirements for special programs.

4.1 General Information
Outpatient diagnostic, therapeutic, and surgical services that are rendered in an acute care hospital setting are services that are provided to clients by or under the direction of a physician.

Outpatient hospital services include those services that are rendered:
- In the emergency room (ER)
- As day surgery
- In the observation room
- By ancillary departments such as the laboratory, radiology, physical or occupational therapy, cardiac rehabilitation, hyperbaric chamber, infusion services, and other areas able to provide services in the outpatient setting.

4.1.1 Drugs and Supplies

4.1.1.1 Self-Administered Drugs
Self-administered drugs are defined as drugs that the client administers themselves at home and may include, but are not limited to, prescription drugs, vitamins, and supplements.

These drugs that are provided by the hospital during an outpatient hospital visit are included in the hospital reimbursement and are not reimbursed separately. The client cannot be billed for self-administered drugs that are provided by the hospital during an outpatient hospital stay.

4.1.1.2 Take-Home Drugs and Supplies
Benefits do not include drugs and biologicals provided by the hospital and taken home by the client. Supplies provided by a hospital for use in physicians’ offices are not reimbursable.

Take-home drugs and supplies are a benefit for services rendered to clients in the outpatient setting when supplied by prescription through the VDP.

4.1.2 Outpatient Services Provided Without Charge
Texas Medicaid pays the clinic registration fee in lieu of other benefits when a hospital provides outpatient services without charge, and if the registration fee is less than the allowed Medicaid payment.

Refer to: TAC Rule §354.1073 for information about authorized outpatient hospital services.

Subsection 1.8, “Texas Medicaid Limitations and Exclusions,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information) for more information about noncovered items or services.

4.1.3 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission
According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

Refer to: Subsection 3.6.3.8, “Payment Window Reimbursement Guidelines,” in this handbook for additional information about the payment window reimbursement guidelines.
4.2 Services, Benefits, Limitations, and Prior Authorization

4.2.1 Prior Authorization Requirements

The hospital is responsible for requesting prior authorization for the non-emergency transport to the client’s home or to a nursing home after a non-scheduled outpatient visit.


4.2.2 Emergency Department Services

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to clients who present for immediate medical attention. The facility must be available 24 hours a day, 7 days a week.

Hospital-based emergency departments are reimbursed for services based on a reasonable cost, based on the hospital’s most recent tentative Medicaid cost report settlement. The reasonable cost is reduced by a percentage determined by the state.

All claims that are submitted by outpatient hospital providers must include a procedure code with each revenue code for services that are rendered to Texas Medicaid clients. This procedure code must be listed on the same claim detail line as the emergency department revenue code.

The procedure code billed may include, but is not limited to, E/M, surgical or other procedure, or any other service rendered to the client in the emergency room. The procedure code must accurately reflect the services rendered in the hospital’s emergency department.

Emergency department reimbursement may include room changes and ancillary changes. Emergency department room charges may be submitted using the following revenue codes:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>450</td>
<td>Emergency room</td>
</tr>
<tr>
<td>451</td>
<td>Emergency room-EMTALA emergency medical screening</td>
</tr>
<tr>
<td>456</td>
<td>Emergency room, urgent care</td>
</tr>
<tr>
<td>459</td>
<td>Emergency room, other</td>
</tr>
</tbody>
</table>

Emergency department ancillary services include, but are not limited to, the following:

- Laboratory services
- Radiology services
- Respiratory therapy services
- Diagnostic studies (including, but not limited to, ECGs, computed tomography (CT) scans, and supplies)

The administration of an injection may be reimbursed to the provider who administers the injection. The administration of the injection will not be reimbursed to outpatient hospital providers. An injection or infusion administered by a nurse is included in the emergency room charge and is not reimbursed separately to the outpatient facility.

Ancillary services must be submitted on the UB-04 CMS-1450 paper claim form using the appropriate procedure codes or revenue codes for rendered services.

If a client visits the emergency room more than once in one day, the times must be given for each visit.
If the client ultimately is admitted as an inpatient within 48 hours of treatment in the ER or clinic, the ER or clinic charges must be submitted on the inpatient hospital claim form as an ancillary charge. The date of inpatient admission is the date the client initially was seen in the ER or clinic.

According to the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986, if any individual presents at the hospital’s emergency department requesting an examination or treatment, the hospital must provide an appropriate medical screening examination and stabilization services within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists.

EMTALA medical screening code (451) may be considered for reimbursement when submitted as a stand-alone service and provided by a qualified medical professional as designated by the facility. Ancillary, professional, or facility services will not be considered for separate reimbursement. Services beyond screening (451) can be submitted with the appropriate corresponding emergency services code (450).

Medicaid claims administrators are prohibited from requiring prior authorization or primary care provider notification for emergency services including those needed to evaluate or stabilize an emergency medical condition or emergency behavioral health condition.

Texas Medicaid provides that certain undocumented aliens and legalized aliens who require treatment of an emergency medical condition or emergency behavioral health condition are eligible to receive that treatment. After the emergency condition requiring care is stabilized and is no longer an emergency, the coverage ends. If the alien continues to receive ongoing treatment after the emergency ceases, the ongoing treatment is not a benefit.

Texas Medicaid provides for medical services for eligible clients while out-of-state. The attending physician or other provider must document that the client was treated for an emergency condition. Out-of-state emergency services are also a benefit when the client’s health would be in danger if he or she were required to travel back to Texas.

Emergency department services are subject to retrospective review.

In instances of sudden illness or injury, the client may receive treatment in the ER and be discharged, placed on observation status, or admitted as an inpatient.

4.2.3 Day Surgery

Inpatients may occasionally require a surgery that has been designated as an outpatient procedure. The physician must document the need for this surgery as an inpatient procedure before the procedure is performed. These claims are subject to retrospective review.

These procedures are for clients who are scheduled for a day surgery procedure and are not inpatient at the time the day surgery is performed.

4.2.3.1 Inpatient Admissions for Day Surgeries

If a client is admitted for a day surgery procedure—whether scheduled or emergency—one of the following classifications may be considered an inpatient procedure.

- ASA Classification of Physical Status of III (P3), IV (P4), or V (P5)
- Classification of Heart Disease IV

The day surgery services must be submitted on an inpatient claim (TOB 111) using the hospital’s provider identifier. The reason for the surgery (principal diagnosis), any additional substantiated conditions, and the procedure must be included on one inpatient claim.

Refer to: The Texas Medicaid Hospital Screening Criteria at www.hhs.state.tx.us/OIG/screen/SC_TOC.shtml#asa, for a description of the ASA classes of physical status.
The descriptions for ASA classes of physical status are as follows:

- **Class I.** A normal healthy patient, without organic, physiological, or psychiatric disturbance.
  
  **Example:** Healthy patient with good exercise tolerance.

- **Class II.** A patient with mild systemic disease, controlled medical conditions without significant systemic effects.
  
  **Example:** Controlled hypertension or diabetes mellitus without system effects, cigarette smoking without evidence of chronic obstructive pulmonary disease (COPD), anemia, mild obesity, age less than 1 or greater than 70 years, or pregnancy.

- **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.
  
  **Example:** Severely limiting organic heart disease, severe diabetes with vascular complications; moderate to severe degrees of pulmonary insufficiency; angina pectoris or healed myocardial infarction.

- **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.
  
  **Example:** Organic heart disease with marked signs of cardiac insufficiency present (for example, cardiac decompensation); persistent anginal syndrome, or active myocarditis; advanced degrees of pulmonary, hepatic, renal, or endocrine insufficiency present.

- **Class V.** The rare person who is moribund (in a dying state) before operation, whose pre-operative condition is such that he or she is expected to die within 24 hours even if not subjected to the additional strain of operation.
  
  **Example:** Burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure; massive embolus.

The Classification of Heart Disease consists of four classes:

- **Class I.** No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpititation, dyspnea, or anginal pain.

- **Class II.** Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpititation, dyspnea, or anginal pain.

- **Class III.** Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpititation, 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.

### 4.2.3.2 Complications Following Elective or Scheduled Day Surgeries

If a condition of the scheduled day surgery requires additional care beyond the recovery period, the client may be placed in outpatient observation (stay less than 48 hours). The observation period must be submitted on an outpatient claim (TOB 131) using the hospital’s provider identifier. If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation placement (excluding the surgical procedure) must be included on the inpatient claim (TOB 111) using the hospital’s provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure must still be submitted as an outpatient procedure under the HASC provider identifier.
4.2.3.3 **Inpatient Admissions After Day Surgery**

If a complication occurs for which the client requires inpatient admission immediately following the day surgery (no observation period), the day surgery must be submitted as an outpatient procedure (TOB 131), using the appropriate hospital or HASC provider identifier. The inpatient admission is to be submitted as an inpatient claim (TOB 111), using the hospital’s provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure must not be included on the inpatient claim. The inpatient admission must be medically necessary and is subject to retrospective review.

4.2.3.4 **Emergency or Unscheduled Day Surgeries**

These procedures are for clients who require an unscheduled (emergency) day surgery procedure and are not inpatient at the time the day surgery is performed.

If a client is first treated in the ER and then requires emergency surgery as an outpatient, claims for emergency, unscheduled outpatient surgical procedures must be filed itemizing each service, such as room charge, laboratory, radiology, anesthesia, and supplies. Providers must submit claims for unscheduled day surgery procedures and emergency services as outpatient procedures using the hospital provider identifier. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status. The observation period must be submitted on the same outpatient claim.

Providers must submit claims for the unscheduled day surgery procedures and emergency services as outpatient procedures (TOB 131) using the hospital’s provider identifier. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status (stay less than 48 hours). The observation period must be submitted on the same outpatient claim (TOB 131) using the hospital’s provider identifier.

4.2.3.5 **Complications Following Emergency or Unscheduled Day Surgery**

If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation status (excluding surgical procedures and emergency services) must be included on the inpatient claim (TOB 111) using the hospital’s provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery and emergency services must not be included on the inpatient claim since they are to be submitted using TOB 131 as outpatient procedures under the hospital’s provider identifier.

4.2.3.6 **Incomplete Day Surgeries**

When HASC providers submit claims to Texas Medicaid for an incomplete surgical procedure, one of the following must be included on the claim:

- Modifier 74 for a discontinued outpatient procedure after anesthesia administration or 73 for a discontinued outpatient procedure prior to anesthesia administration.
- At least one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V641</td>
<td>Surgical or other procedure not carried out because of contraindication</td>
</tr>
<tr>
<td>V642</td>
<td>Surgical or other procedure not carried out because of patient’s decision</td>
</tr>
<tr>
<td>V643</td>
<td>Procedure not carried out for other reasons</td>
</tr>
</tbody>
</table>

Claims that are submitted with diagnosis codes V641, V642, 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 HASC facilities for canceled or incomplete surgeries because of patient complications, is made according to the following criteria, depending on the extent to which the anesthesia or surgery proceeded:

- Reimburse at 0 percent of HASC 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 HASC group payment schedule up to the administration of anesthesia.
- Reimburse at 67 percent of HASC group payment schedule after the administration of anesthesia but before incision.
- Reimburse at 100 percent of HASC group payment schedule after incision.

Surgeries canceled because of incomplete pre-operative procedures are not reimbursed.

**4.2.4 Outpatient Observation Room Services**

Observation care is defined by the CMS as “a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether clients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”

Outpatient observation services are usually ordered for clients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision about their admission or discharge. The decision whether to discharge a client from the hospital following resolution of the reason for the observation care or to admit the client as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Outpatient observation services require the use of a hospital bed and periodic monitoring by the hospital’s nursing or other ancillary staff to evaluate the client’s condition and to determine the need for an inpatient admission. Outpatient observation services can be provided anywhere in the hospital. The level of care, not the physical location of the bed, dictates the observation status.

Outpatient observation services (revenue code 762) are a benefit only when medically necessary and when provided under a practitioner’s order or under the order of another person who is authorized by state licensure law and hospital bylaws to admit clients to the hospital and to order outpatient services.

Outpatient observation services are considered medically necessary if the following conditions are met (this list is not all-inclusive):

- The client is clinically unstable for discharge and one of the following additional conditions apply:
  - Laboratory, radiology, or other testing is necessary to assess the client’s need for an inpatient admission.
  - The treatment plan is not established or, based on the client’s condition, is anticipated to be completed within a period not to exceed 48 hours.
  - The client had a significant adverse response to therapeutic services, invasive diagnostic testing, or outpatient surgery and requires short-term monitoring or evaluation.
- The medical necessity for inpatient treatment is unclear, that is:
  - The client’s medical condition requires careful monitoring and evaluation, or treatment to confirm or refute a diagnosis in order to determine whether an inpatient admission is necessary.
  - There is a delayed or slow progression of the client’s signs and symptoms that makes diagnosis difficult and the monitoring or treatment does not meet the criteria for an inpatient level of care.
  - The client is undergoing treatment for a diagnosed condition, and continued monitoring of clinical response to therapy may prevent an inpatient admission.
The admitting practitioner anticipates that the client will require observation care for a minimum of eight hours.

Medically necessary services that do not meet the definition of observation care should be submitted separately or included as part of the emergency department or clinic visit, and are not reimbursed as observation care.

Outpatient observation services are not a substitute for a medically appropriate inpatient admission. If a client meets the medical necessity criteria for an inpatient admission and an inpatient admission is ordered by the practitioner, an inpatient admission is a benefit regardless of the length of stay. Claims for observation services may be denied in their entirety if the services should have initially been inpatient admissions or if a reason for an inpatient admission developed, but the observation stay was not converted to inpatient.

The determination of an inpatient or outpatient status for any given client is specifically reserved to the admitting practitioner. The decision must be based on the practitioner’s expectation of the care that the client will require.

4.2.4.1 Direct Outpatient Observation Admission
A client may be directly admitted to outpatient observation from the evaluating practitioner’s office without being seen in the emergency room by a hospital-based practitioner. The practitioner’s order should clearly specify that the practitioner wants the client to be admitted to outpatient observation status. An order for “direct admission” will be considered an inpatient admission unless otherwise specified by the practitioner’s orders.

Brief observation periods following an office visit or at the direction of an off-site practitioner that involve a simple procedure (e.g., a breathing treatment) would be more appropriately coded as a treatment room visit.

4.2.4.2 Observation Following Emergency Room
A client may be admitted to outpatient observation through the emergency room if the client presents to the facility with an unstable medical condition and the evaluating practitioner determines that outpatient observation is medically necessary to determine a definitive treatment plan. An unstable medical condition is defined as one of the following:

- A variance in laboratory values from what is considered the generally accepted, safe values for the individual client.
- Clinical signs and symptoms that are above or below those of normal range and that require extended monitoring and further evaluation.
- Changes in the client’s medical condition are anticipated, and further evaluation is necessary.

If a client is admitted to observation status from the emergency room, the hospital is reimbursed only for the observation room charges. The emergency room charges are not reimbursed separately, but must be submitted on a separate detail on the same claim as the observation room charges.

Brief observation periods following an emergency room evaluation will not be reimbursed if the service would normally have been provided within the time frames and facilities of an emergency room visit.

4.2.4.3 Observation Following Outpatient Day Surgery
If a medical condition or complication of a scheduled day surgery requires additional care beyond the routine recovery period, the client may be placed in outpatient observation. The observation period should be submitted as an outpatient claim.
Reimbursement for outpatient observation after a scheduled day surgery is limited to situations in which the client exhibits an unusual reaction to the surgical procedure and requires monitoring or treatment beyond what is normally provided in the immediate post-operative period. Examples include, but are not limited to:

- Difficulty in awakening from anesthesia.
- A drug reaction.
- Other post-surgical complications.

### 4.2.4.4 Observation Following Outpatient Diagnostic Testing or Therapeutic Services

A client may be admitted to outpatient observation if the client develops a significant adverse reaction to a scheduled outpatient diagnostic test or to a therapeutic service, such as chemotherapy, that requires further monitoring. Observation services begin when the reaction occurred and end when the practitioner determines that the client is stable for discharge, or that an inpatient admission is appropriate.

### 4.2.4.5 Documentation Requirements for Outpatient Observation

Documentation that supports the medical necessity of the outpatient observation services must be maintained by the facility in the client’s medical record. Documentation must include:

- The order of the ordering practitioner for admission to observation care, which must be dated and timed.
- The practitioner’s admission and progress notes, which must be dated and timed, confirm the need for observation care, and outline the client’s condition, treatment, and response to treatment.
- Nurse’s notes, which must be dated and timed, reflect the time at which the client was admitted to the observation bed, and the reason for the observation stay.
- All supporting diagnostic and ancillary testing reports, including orders for the testing or any preadmission testing.
- Procedure notes and operative notes that address any complication that would support admission to observation status and must be dated and timed.
- Anesthesia and recovery room/post anesthesia care unit notes from the practitioner and the nurse, which must be dated and timed and detail orders and any complications that require admission to observation status.
- Documentation related to an outpatient clinic visit or critical care service that was provided on the same date of service as the observation service. The documentation must address any need for observation services and be dated and timed.
- All of the client education that was provided during the observation stay.
- The order for discharge from observation care, which must be signed, dated, and timed.
- The discharge notes, including nurse’s notes that reflect the date and time at which the client was discharged from observation.

The client must be in the care of a practitioner during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are dated, timed, written, and signed by the practitioner.

Claims submitted for outpatient procedures in which the original intention was to keep the client for an extended period of time, such as overnight or for a 48-hour period, will be denied unless significant medical necessity is documented.
Retrospective review may be performed to ensure that the documentation supports the medical necessity of the outpatient observation services. Medical records will be evaluated to determine whether the practitioner’s order (practitioner intent) and the services that were actually provided were consistent.

The medical records must clearly support the medical necessity of the outpatient observation services and must include a timed order for observation services that will support the number of hours that the client was under observation care and the hours that were submitted for payment.

4.2.4.6 Reporting Hours of Operation

Providers must submit the number of observation hours the client was under observation care.

Observation time begins at the clock time documented in the client’s medical record. This time should coincide with the time that the client is placed in a bed for the purpose of initiating observation care in accordance with the practitioner’s order.

Observation time ends when all medically necessary services related to observation care are completed. The end time of observation services may coincide with the time the client is actually discharged from the hospital or is admitted as an inpatient.

Hospitals should round clock times for the beginning and end of observation to the nearest hour and submit the total number of hours for the observation stay on the claim. For the purposes of submitting claims for observation services, one unit equals one hour. Partial units or hours should be rounded up or down to the nearest hour. Claims submitted with observation room units exceeding 48 hours will be denied.

Any service that was ordered within the observation period may be included on the outpatient claim if a practitioner’s order for the service was made within the observation period time frame but hospital scheduling limitations prevented the service from being performed before the 48 hours expired. Any services ordered after 48 hours must not be included on the outpatient claim nor billed to the client. If a period of observation spans more than one calendar day (i.e., extends past midnight), all of the hours for the entire period of observation must be included on a single line, and the date of service for that line is the date on which the observation care began.

Observation time may include medically necessary services and follow-up care that is provided after the time the practitioner writes the discharge order, but before the client is discharged. Reported observation time does not include the time the client remains in the observation area after treatment is completed for reasons such as waiting for transportation home.

Observation services must not be submitted concurrently with diagnostic or therapeutic services for which active monitoring is part of the procedure. In situations where a diagnostic or therapeutic procedure interrupts the observation stay, hospitals should record for each period of observation services the beginning and ending times of the observation period and add the lengths of time for the periods of observation services together to reach the total number of units reported on the claim.

Recovery room hours that are associated with an outpatient procedure must not be submitted simultaneously with hours of observation time.

Revenue code 761 will be denied if it is submitted for the same date of service by the same provider as revenue code 760, 762, or 769.

4.2.4.7 Client Status Change

When a client’s status changes from outpatient observation to inpatient admission within the allowed 48-hour observation period, both the outpatient observation service and the inpatient admission must be submitted as separate details on the same inpatient claim. When a client’s status changes from observation to inpatient admission, the date of the inpatient admission is the date the client was placed on observation status. The practitioner’s order for a change in client status from outpatient observation to inpatient admission must be written, dated, and timed before the client’s discharge.
When a client is admitted to the hospital as an inpatient and a subsequent internal utilization review (UR) determines that the services did not meet inpatient criteria, the hospital may change the client’s status from inpatient to outpatient observation. The order to change from an inpatient to outpatient observation admission is effective for the same date and time as the inpatient order. This practice is acceptable under Texas Medicaid if all of the following conditions are met:

- The change in client status is made before discharge or release while the client is still a patient of the hospital.
- The hospital has not submitted a claim for the inpatient admission.
- The practitioner responsible for the care of the client concurs with the hospital UR committee’s determination.
- The practitioner’s concurrence with the UR committee’s decision is documented in the client’s medical record.

Reimbursement for emergency room (ER) and observation services are considered part of the inpatient diagnosis related group (DRG) payment and must be submitted as separate details on the inpatient claim when the client is admitted as an inpatient under one or both of the following circumstances:

- The client has spent fewer than 24 hours after presenting in the ER without being placed in observation status.
- The client has spent fewer than 48 hours in observation status after presenting in the ER.

The date of admission on the inpatient claim must reflect the date the client presents at the hospital. If the client is admitted as an inpatient more than 24 hours after presenting in the ER without being placed in observation status or more than 48 hours after being placed in observation status, the ER and observation services may be reimbursed separately as outpatient services.

**Examples**
The following examples indicate the appropriate dates of admission and claim submissions for different scenarios:

**Scenario 1**
In scenario 1, the ER and outpatient observation services must be submitted on the inpatient hospital claim, because the ER services are within 24 hours of the observation services, and the observation services are within 48 hours of the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient presented at the ER.

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Patient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/1/12 (11:50 p.m.)</td>
<td>Patient presents in the ER</td>
</tr>
<tr>
<td>5/2/12 (12:30 a.m.)</td>
<td>40 minutes later, patient is placed in observation status</td>
</tr>
<tr>
<td>5/3/12 (12:00 a.m.)</td>
<td>23.5 hours later, after placement is in observation status, patient is admitted as an inpatient</td>
</tr>
</tbody>
</table>

Claims submissions are as follows:

- **ER visit**: Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- **Observation services**: Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- **Date of inpatient admission**: May 1, 2012
Scenario 2
In scenario 2, the ER service was more than 24 hours before the observation period began and must be submitted on an outpatient hospital claim. The observation service must be billed on the inpatient hospital claim because the service was within 48 hours of the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient was placed in observation status.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>5/1/12 (11:50 p.m.)</td>
<td>Patient presents in the ER</td>
</tr>
<tr>
<td>5/2/12 (11:55 p.m.)</td>
<td>24 + hours later, patient is placed in observation status</td>
</tr>
<tr>
<td>5/3/12 (4:00 a.m.)</td>
<td>4 hours later, patient admitted as an inpatient</td>
</tr>
</tbody>
</table>

Claims submissions are as follows:

- **ER visit**: Submitted on an outpatient claim and reimbursed separately from the observation and inpatient services
- **Observation services**: Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- **Date of inpatient admission**: May 2, 2012

Scenario 3
In scenario 3, the ER service must be submitted on an outpatient claim as part of the observation service because the ER service was within 24 hours of the observation service. The observation service may be reimbursed separately from the inpatient admission because the observation service was more than 48 hours before the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient was admitted as an inpatient.

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Patient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/1/12 (11:50 p.m.)</td>
<td>Patient presents in the ER</td>
</tr>
<tr>
<td>5/2/12 (12:30 a.m.)</td>
<td>40 minutes later, patient placed in observation status</td>
</tr>
<tr>
<td>5/4/12 (12:45 a.m.)</td>
<td>48 + hours later patient admitted as an inpatient</td>
</tr>
</tbody>
</table>

Claims submissions are as follows:

- **ER visit**: Submitted on an outpatient claim and reimbursed as part of the outpatient observation services
- **Observation services**: Submitted on the outpatient claim and reimbursed separately from the inpatient services
- **Date of inpatient admission**: May 4, 2012

Scenario 4
In scenario 4, the ER service may be reimbursed separately because it was more than 24 hours before the client was placed in observation status. The observation service may be reimbursed separately because it was more than 48 hours before the client was admitted as an inpatient.

The inpatient admission date reflects the date the patient was admitted as an inpatient.

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Patient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/1/12 (11:50 p.m.)</td>
<td>Patient presents in the ER</td>
</tr>
</tbody>
</table>
Claims submissions are as follows:

- **ER visit**: Submitted on an outpatient claim and reimbursed separately from the observation and inpatient services.

- **Observation services**: Submitted on an outpatient claim and reimbursed separately from the inpatient services.

- **Date of inpatient admission**: May 4, 2012

**Scenario 5**
In scenario 5, the ER service must be submitted on an outpatient claim as part of the observation service because the ER service was within 24 hours of the observation service. The observation service may be reimbursed separately from the inpatient admission because the client was discharged and sent home without being admitted as an inpatient.

The inpatient admission date reflects the date the patient presented at the ER after being discharged and sent home 14 hours earlier.

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Patient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/1/12 (11:50 p.m.)</td>
<td>Patient presents in the ER</td>
</tr>
<tr>
<td>5/2/12 (12:30 a.m.)</td>
<td>40 minutes later, patient is placed in observation status.</td>
</tr>
<tr>
<td>5/2/12 (10:00 a.m.)</td>
<td>9.5 hours later, patient is discharged and sent home</td>
</tr>
<tr>
<td>5/3/12 (12:05 a.m.)</td>
<td>14 hours later, patient presents at the ER again and is admitted as an inpatient</td>
</tr>
</tbody>
</table>

Claims submissions are as follows:

- **ER visit**: Submitted on an outpatient claim and reimbursed as part of the observation services.

- **Observation services**: Submitted on the outpatient claim and reimbursed separately from the inpatient services.

- **Date of inpatient admission**: May 3, 2012

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be submitted as an outpatient episode of care.

### 4.2.4.8 Observation Services that are not a benefit

Outpatient observation services that are not medically necessary or appropriate are not benefits of Texas Medicaid, including, but not limited to, services provided under the following circumstances:

- As a substitute for an inpatient admission.

- Without a practitioner’s order, including services ordered as inpatient services by the ordering practitioner, but submitted as outpatient by the billing office.

- For clients awaiting transfer to another facility, such as for nursing home placement.

- For clients with lack of or delay in transportation.

- As a convenience to the client, client’s family, the practitioner, hospital, or hospital staff.

- For routine preparation before, or recovery after, outpatient diagnostic or surgical services.
• When an overnight stay is planned before diagnostic testing.
• To medically stable clients who need diagnostic testing or outpatient procedures that are routinely provided in an outpatient setting.
• Following an uncomplicated treatment or procedure.
• As standing orders for observation following outpatient surgery.
• For postoperative monitoring during a standard recovery period of four to six hours, which is considered part of the recovery room service.
• For outpatient blood or chemotherapy administration and concurrent services.
• For services that would normally require an inpatient admission.
• Beyond 48 hours from the time of the observation admission.
• For a medical examination for clients who do not require skilled support.

4.2.5 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 submitted for general medical services: AH, AJ, AM, SA, TD, TE, or U7.

The services listed below must be submitted 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 submitted 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 submitting a claim on the CMS-1500 paper claim form, providers must 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 submitted using the individual or group physician provider identifier.

Hospital-based RHCS must submit claims for pneumococcal and influenza vaccines as non-RHC services, under their hospital provider identifier.

Note: 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.
4.2.6 * Cardiac Rehabilitation

Cardiac rehabilitation is a physician-supervised program that furnishes physician-prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment.

Outpatient cardiac rehabilitation is considered reasonable and necessary for clients who have had one of the following within 12 months of beginning the cardiac rehabilitation program:

- Acute myocardial infarction
- Coronary artery bypass surgery (CABG)
- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart valve repair or replacement
- Major pulmonary surgery
- Sustained ventricular tachycardia or fibrillation
- Class III or class IV congestive heart failure
- Chronic stable angina

**Note:** A cardiac rehabilitation program in which the cardiac monitoring is done using telephonically transmitted electrocardiograms to a remote site is not covered by Texas Medicaid.

Cardiac rehabilitation must be provided in a facility that has the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment (i.e. oxygen, cardiopulmonary resuscitation equipment, or defibrillator) available for immediate use. If no clinically significant arrhythmia is documented during the first three weeks of the program, the provider may have the client complete the remaining portion without telemetry monitoring by the physician’s order.

Although cardiac rehabilitation may be considered a form of physical therapy, it is a specialized program conducted by non-physician personnel who are trained in both basic and advanced cardiac life support techniques and exercise therapy for coronary disease, and provide the services under the direct supervision of a physician.

**Direct supervision of a physician means that a physician must be immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under cardiac rehabilitation programs.** Outpatient cardiac rehabilitation begins after the client has been discharged from the hospital. A physician’s prescription is required after the acute convalescent period and after it has been determined that the client’s clinical status and capacity will allow for safe participation in an individualized progressive exercise program. Outpatient cardiac rehabilitation requires close monitoring and direct supervision by a physician and includes:

- Medical evaluation performed by the physician responsible for prescribing the client’s rehabilitation program and includes a clinical examination, a medical history, and an initial plan or goal.
- An education and counseling program to modify risk factors (nutritional counseling, stress reduction, smoking cessation, weight loss, etc.).
- Prescribed exercise concurrent with and without electrocardiogram (ECG) monitoring.
- Services performed in an approved facility by trained professionals.

**Note:** Direct supervision is met when the services are performed on hospital premises or within 250 yards of the hospital.

Cardiac rehabilitation will be limited to a maximum of 2 one-hour sessions per day and 36 sessions over 18 weeks per rolling year.
Providers must obtain prior authorization for additional cardiac rehabilitation sessions, which will be limited to a maximum of 36 sessions in an extended period of time in a 52-week period from the date of authorization of additional sessions.

To confirm that a continuation of cardiac rehabilitation is at the request of, and coordinated with the attending physician, the medical record must include evidence of communication between the cardiac rehabilitation staff and either the medical director or the referring physician. If the physician responsible for such follow-up is the medical director, then his or her notes must be evident in each client’s medical record.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions if the medical record contains documentation that the client has had another cardiac event, or if the prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. Medical necessity documentation must include the following:

- Progress made from the beginning of the cardiac rehabilitation period to the current service request date, including progress towards previous goals
- Information that supports the client’s capability of continued measurable progress
- A proposed treatment plan for the requested extension dates with specific goals related to the client’s individual needs

Prior authorization must be obtained through the TMHP Special Medical Prior Authorization (SMPA) Department. Providers must send prior authorization requests, along with documentation to support medical necessity, to the following address:

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

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.

The evaluation provided by the cardiac rehabilitation team at the beginning of each cardiac rehabilitation session is not considered a separate service and will be included in the reimbursement for the cardiac rehabilitation session. Evaluation and management (E/M) services unrelated to cardiac rehabilitation may be submitted with modifier 25 appended to the E/M code when supporting documentation in the medical record demonstrates a separately identifiable E/M service was provided on the same day by the same provider who renders the cardiac rehabilitation.

Physical and occupational therapy will not be reimbursed separately when furnished in addition to cardiac rehabilitation exercise program services unless there is also a diagnosis of a non-cardiac condition requiring such therapy.

**Example:** If a client is recuperating from an acute phase of heart disease and has had a stroke that requires physical or occupational therapy, the physical or occupational therapy for the stroke may be reimbursed separately from the cardiac rehabilitation services for the acute phase of heart disease.

When provided as part of the cardiac rehabilitation program, client education services, such as formal lectures and counseling on diet, nutrition, and sexual activity to assist the client in adjusting living habits because of the cardiac condition, will not be separately reimbursed.
Hospitals may be reimbursed for revenue code 943 when submitted with procedure code S9472 and one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>40201</td>
</tr>
<tr>
<td>41030</td>
</tr>
<tr>
<td>41061</td>
</tr>
<tr>
<td>41092</td>
</tr>
<tr>
<td>42822</td>
</tr>
<tr>
<td>4289</td>
</tr>
</tbody>
</table>

Note: Revenue code 943 is the code that will be reimbursed. Procedure code S9472 is required on the claim but is informational only.

4.2.7 Chemotherapy Administration
Hospitals must submit outpatient charges using the appropriate revenue codes for room charges, supplies, IV equipment, and pharmacy.

Revenue code 636 may be reimbursed for the technical component of prolonged infusion of chemotherapeutic agents. The most appropriate chemotherapy procedure code must be billed with revenue code 636.


4.2.8 Colorectal Cancer Screening
Procedure code G0122 may be reimbursed once every 5 years for services rendered to clients who are 50 years of age and older.

Procedure code G0106 may be reimbursed once every 5 years and is limited to one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1090</td>
</tr>
</tbody>
</table>

Procedure code G0120 may be reimbursed when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5550</td>
</tr>
<tr>
<td>55841</td>
</tr>
</tbody>
</table>

Procedure code G0328 may be reimbursed once a year for services rendered to clients who are 50 years of age and older.

Procedure code G0122 may be reimbursed once every 5 years for services rendered to clients who are 50 years of age and older.

4.2.9 Computed Tomography and Magnetic Resonance Imaging

Prior authorization is required for all outpatient nonemergent (i.e., those that are scheduled) CT, computed tomography angiography (CTA), magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA) studies before services are rendered. Authorization is not required for the emergency department or inpatient hospital radiology services. Retroactive authorization may be required for some outpatient emergent studies.

Reimbursement for procedures with descriptions that specify “with contrast” include payment for contrast materials. Some diagnostic radiopharmaceuticals are benefits of Texas Medicaid. Outpatient hospitals may submit the total component of the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>77371</td>
</tr>
</tbody>
</table>

Procedure code 77399 may be submitted as either the total component or the technical component.

Providers can refer to the OFL or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid. OFL and static fee schedules available on the TMHP website display fees after applicable rate reductions have been applied. Previously, the OFL and static fee schedules did not reflect all rate reductions, and providers were required to calculate the 1- and 2-percent reductions implemented.

Refer to: Subsection 4.2.9, “Computed Tomography and Magnetic Resonance Imaging,” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks), for additional information about prior authorization requirements.

Subsection 3.2.6, “Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services,” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for additional information about emergency outpatient imaging services.

4.2.10 Electrodiagnostic (EDX) Testing

Electromyography (EMG) and nerve conduction studies (NCS), collectively known as EDX testing, must be medically indicated and may be reimbursed to outpatient hospitals. Testing must be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening purposes rather than diagnoses are not a benefit of Texas Medicaid.

NCS and EMG studies are diagnosis restricted and may require prior authorization.


4.2.11 Fluocinolone Acetonide

The fluocinolone acetonide intravitreal implant (procedure code J7311) may be reimbursed for services rendered to clients who are 12 years of age and older. Procedure code J7311 requires prior authorization.
4.2.11.1 Prior Authorization for Fluocinolone Acetonide

Procedure code J7311 is only payable with a posterior uveitis diagnosis (36320) of more than six months duration and the condition has been unresponsive to oral or systemic medication treatment. To request prior authorization, providers must submit requests by fax or mail to the SMPA Department at:

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

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

4.2.12 Fetal Nonstress Testing and Contraction Stress Test

Claims for nonstress and contraction stress testing conducted in the outpatient setting must be submitted with revenue code 729. Services during an inpatient hospital stay are reimbursed under the hospital’s DRG.


4.2.13 * Hyperbaric Oxygen Therapy (HBOT)

HBOT is a type of therapy that increases the environmental oxygen pressure to promote the movement of oxygen from the environment into the client’s body tissues. Such treatment may be a benefit of Texas Medicaid when it is performed in specially constructed hyperbaric chambers, pressurized to 1.4 atmosphere absolute (atm abs) or higher, which may hold one or more clients.

Sea-level pressure is equal to atm.abs). Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, this use of oxygen is not considered hyperbaric oxygen treatment in itself. HBOT procedure codes 1-99183 and 1-C1300 require prior authorization before the date that service is initiated.

The number of billable units of procedure code 1-C1300 is based upon the time that the client receives treatment with hyperbaric oxygen.

In calculating how many 30-minute intervals to report, hospitals should take into consideration the time spent under pressure during descent, airbreaks, and ascent, (in minutes), as follows:

- The first unit is for the time spent in the chamber receiving hyperbaric oxygen and must be for a minimum of 16 minutes.
- To bill for a second (or subsequent unit), all previous units of time must have been for the full thirty minutes, and the last unit must be for 16-30 minutes.

Procedure code 1-99183 equates to one total treatment (one professional session).

Procedure code 1-C1300 must be billed with revenue code B-413 on the same claim. If procedure code 1-C1300 is not on the same claim as revenue code B-413, the claim will be denied.

Refer to: Subsection 8.2.33, “Hyperbaric Oxygen Therapy (HBOT),” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for more information.
4.2.14 Laboratory Services

Routine laboratory services, directly related to the surgical procedure being performed, are not reimbursed separately. Claims for nonroutine laboratory services provided with emergency conditions may be submitted separately with documentation that the complicating condition arose after the initiation of the surgery. Outpatient claims for laboratory services must reflect only tests actually performed by the hospital laboratory.

Exception: Hospital laboratories may submit claims for all the tests performed on a specimen if some but not all the tests are done by another laboratory on referral from the hospital submitting the claim.

The billing hospital must enter the name and provider identifier of the performing laboratory in Block 80 of the UB-04 CMS-1450 paper claim form and must enter the performing laboratory’s provider identifier next to the service provided by the performing laboratory.

Hospitals may submit claims for a handling fee (procedure code 99001) for collecting and forwarding a specimen to a referral laboratory when the laboratory handling fee is not being billed through other methods. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories; this must be documented on the claim.

Refer to: The Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).

4.2.14.1 Clinical Laboratory Improvement Amendments (CLIA)

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying 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 about enrollment procedures.

Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA),” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for more information about CLIA.

The Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

4.2.15 Lung Volume Reduction Surgery (LVRS)

LVRS surgery must be performed at a facility certified under the Disease Specific Care Certification Program for LVRS by the Joint Commission of Health Care Organization and identified by the National Heart, Lung, and Blood Institute, and at sites that have been approved by Medicare as lung transplant facilities.

LVRS surgery must be preceded and followed by a program of diagnostic and therapeutic services consistent with those provided in the National Emphysema Treatment Trial (NETT) and designed to maximize the potential to successfully undergo and recover from surgery. The program must be arranged, monitored, and performed under the coordination of the facility where the surgery takes place, and must include all of the following:

• A 6- to 10-week series of pre-operative sessions.

• A series of postoperative sessions within 8 to 9 weeks of the LVRS.

• It must be consistent with the plan of care developed by the treating physician following performance of a comprehensive evaluation of the client’s medical, psychosocial, and nutritional needs.

• It must be consistent with the pre-operative and post-operative services provided in the NETT study.

Prior authorization is required for the LVRS procedure. However; prior authorization is not required for the pre-operative and post-discharge pulmonary services.
An outpatient facility must submit claims that include revenue code 469 and one of the pre-operative rehabilitation service procedure codes for preparation for LVRS (procedure code G0302, G0303, or G0304) or for the post-discharge surgery services after LVRS (procedure code G0305). These services are restricted to diagnosis code 4928.

Procedure codes G0302, G0303, and G0304 are limited to once per rolling year, per client for any provider. Only one pre-operative pulmonary rehabilitation service will be reimbursed per client. Post-discharge pulmonary surgery services after LVRS (procedure code G0305) are limited to once per rolling year per client for any provider and only if a claim for procedure code 32491 has been submitted in the past 12 months. Procedure code G0305 may be considered on appeal with documentation of LVRS surgery performed in the previous 12 months.

4.2.16 Neurostimulators

Neurostimulators may be a benefit in the outpatient hospital setting when medically necessary. All procedures require prior authorizations.


4.2.16.1 Prior Authorization for Neurostimulators

All devices and related procedures for the initial application or surgical implantation of the stimulator device require prior authorization. Requests for prior authorization must be submitted to the SMPA Department.


4.2.17 Occupational and Physical Therapy Services

Refer to: The Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks) for more information about therapy services.

4.2.18 Radiation Therapy Services

Take-home drugs given during the course of therapy can be reimbursed separately through the VDP. Hospitals use revenue code 333, Radiation therapy, on the UB-04 CMS-1450 paper claim form when submitting charges for these services.

The following radiation therapy services provided in an outpatient setting are allowed only once per day unless documentation of medical necessity supports the need for repeated services:

- Therapeutic radiation treatment planning
- Therapeutic radiology simulation-aided field setting
- Teletherapy
- Brachytherapy isodose calculation
- Treatment devices
- Proton beam delivery/treatment
- Intracavity radiation source application
- Interstitial radiation source application
- Remote afterloading high intensity brachytherapy
- Radiation treatment delivery
• Localization, and radioisotope therapy

**4.2.18.1 Radiopharmaceuticals**

Radiopharmaceuticals may be considered for separate reimbursement when used for therapeutic treatment.

The following procedure codes are payable to outpatient hospitals

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>79403*</td>
</tr>
<tr>
<td>A9542</td>
</tr>
<tr>
<td>A9543</td>
</tr>
<tr>
<td>A9545</td>
</tr>
<tr>
<td>A9563</td>
</tr>
<tr>
<td>A9564</td>
</tr>
<tr>
<td>A9600</td>
</tr>
<tr>
<td>A9699</td>
</tr>
</tbody>
</table>

*Total or technical component

Procedure codes A9542, A9543, and A9545 require prior authorization. Only one of these agents may be considered per lifetime by any provider. Procedure codes A9542, A9543, A9545 must be submitted with diagnosis code 20280.

Procedure code A9600 is limited to diagnosis code 1985 and to one service per day by the same provider with a total of 10 mci intravenously injected every 90 days, by any provider.

Procedure code A9563 is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
</tr>
<tr>
<td>20410</td>
</tr>
<tr>
<td>20412</td>
</tr>
<tr>
<td>20422</td>
</tr>
<tr>
<td>20492</td>
</tr>
<tr>
<td>20510</td>
</tr>
<tr>
<td>20512</td>
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<tr>
<td>20522</td>
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<tr>
<td>20582</td>
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<tr>
<td>20592</td>
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<tr>
<td>20812</td>
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<tr>
<td>20822</td>
</tr>
<tr>
<td>20892</td>
</tr>
<tr>
<td>2384</td>
</tr>
</tbody>
</table>

Procedure code A9564 is limited to diagnosis code 1972 or 1976. Modifier 76 must be used when submitting a claim for a radiopharmaceutical procedure code more than once per day by the same provider.

Refer to: Subsection 8.2.64, “Radiation Therapy,” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks).*

**Prior Authorization for Therapeutic Radiopharmaceuticals**

Prior authorization is required for A9542, A9543, and A9545, which will be considered with documentation of all of the following:

• A diagnosis of either a low-grade follicular or transformed B-cell non-Hodgkin’s lymphoma.

• Client has failed, relapsed, or become refractory to conventional chemotherapy.

• Marrow involvement is less than 26 percent.

• Platelet count is 100,000 cell/mm³ or greater.

• Neutrophil count is 1,500 cells/mm³ or greater.

• Client has failed a trial of rituximab.

Prior authorization must be requested through the SMPA department with appropriate documentation. Requests can be mailed or faxed to:

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

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.
4.2.19 Respiratory Services

4.2.19.1 Aerosol Treatment

Aerosol treatments, including vaporizers, humidifiers, nebulizers, and inhalers are a benefit of Texas Medicaid. Authorization is not required for aerosol treatments.

The following diagnosis codes are payable for aerosol treatments:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1363 27700 27701 27702 27703 27709 46611 46619 4801 48242</td>
</tr>
<tr>
<td>486 48801 48802 48811 48812 4910 4911 49120 49121 49122</td>
</tr>
<tr>
<td>4918 4919 4920 4928 49300 49301 49302 49310 49311 49312</td>
</tr>
<tr>
<td>49320 49321 49322 49381 49382 49390 49391 49392 4940 4941</td>
</tr>
<tr>
<td>4950 4951 4952 4953 4954 4955 4956 4957 4958 4959</td>
</tr>
<tr>
<td>496 5070 5071 5078 51911 51919 5533 7707 99527 99731</td>
</tr>
<tr>
<td>99739</td>
</tr>
</tbody>
</table>

Revenue code 412 may be reimbursed separately when submitted for aerosol therapy in the recovery room after outpatient surgery, as it is a necessary adjunct to the postoperative recovery of a client who has undergone general anesthesia.

Outpatient facilities must submit claims for aerosol treatments using revenue code 412. Revenue code 412 includes the inhalers listed below and is payable once per day in the outpatient setting for either the aerosol therapy or the inhaler, but not both.

- Beclomethasone dipropionate (Vanceril or Beclovent oral inhalers)
- Isoproterenol sulfate (Iso-Autohaler, Luf-Iso Inhaler, Medihaler-Is, Norisodrine Aerohaler)
- Isoproterenol hydrochloride (Iprenol, Vapo-Iso inhalers)
- Bilateral (Proventil or Ventolin inhalers)
- Metaproterenol sulfate (Alupent Metered Dose inhaler, Metaprel inhaler, Alupent 10 mL, Alupent 30 mL)
- Epinephrine bitartrate (Medihaler-Epi and Primatene Mist Suspension inhaler)
- Phenylephrine bitartrate (Duo-Medihaler)
- Isoetharine mesylate inhalation aerosol (Bronkometer)
- Dexamethasone sodium phosphate (Turbinaire or Resphaler)

Demonstration and evaluation of client utilization of an aerosol generator, nebulizer, metered dose inhaler, or intermittent positive pressure breathing (IPPB) device will not be reimbursed separately.

IPPB treatments have been determined to be inappropriate for the treatment of most respiratory problems and are denied.

4.2.19.2 Pentamidine Aerosol

Aerosol pentamidine treatments are reimbursed using procedure code 94642. The provider may also be reimbursed for the medication using procedure code J2545.

Payment for aerosol pentadamine treatments is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>042 07951 07952 07953 1363 48284 5186</td>
</tr>
</tbody>
</table>
Aerosol pentamidine treatments are limited to one treatment every 28 days.

Oral trimethoprim-sulfamethoxazole is available from pharmacies for self administration at home. The use of oral trimethoprim-sulfamethoxazole is not a payable benefit of the insured portion of Texas Medicaid.

### 4.2.19.3 Pulmonary Function Studies

Pulmonary function studies considered for reimbursement to outpatient hospitals include, but are not limited to, the following procedures when submitted with the total component (TOS 5):

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>94010</td>
</tr>
<tr>
<td>94453</td>
</tr>
</tbody>
</table>

Procedure codes 94452 and 94453 must be submitted with one of the following diagnosis codes. Additionally, evidence of hypoxemia must be documented in the client’s medical record.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>27700</td>
</tr>
<tr>
<td>4169</td>
</tr>
<tr>
<td>4920</td>
</tr>
<tr>
<td>5089</td>
</tr>
<tr>
<td>5181</td>
</tr>
</tbody>
</table>

When multiple procedure codes are submitted, the most inclusive code of the related codes will be reimbursed and all other related codes will be denied.

When unrelated pulmonary function studies are submitted together, each will be considered for reimbursement.

### 4.2.20 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a comprehensive, public health approach to the delivery of early intervention and treatment services for clients with substance use disorders and those at risk of developing such disorders. Substance abuse includes, but is not limited to, the abuse of alcohol and the abuse of, improper use of, or dependency on illegal or legal drugs. SBIRT is used for intervention directed to individual clients and not for group intervention. SBIRT is targeted to clients who are 14 years of age through 20 years of age and who present to the hospital emergency department for a traumatic injury, condition, or accident related to substance abuse. SBIRT may also be medically necessary for clients who are 10 years of age through 13 years of age.

Claims for the first SBIRT session, including screening and brief intervention, must be submitted by the hospital using an appropriate revenue code and procedure code H0050. Screening to identify clients with problems related to substance use must be performed during the first session in the hospital emergency department or inpatient setting, but will not be separately reimbursed.

Screening may be completed through interview and self-report, blood alcohol content, toxicology screen, or by using a standardized tool. Standardized tools that may be used include, but are not limited to, the following:

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
• Cut-down, Annoyed, Guilty, Eye-opener (CAGE) questionnaire
• Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) questionnaire
• Binge drinking questionnaire

Brief intervention is performed during the first session following a positive screen or a finding of at least a moderate risk for substance or alcohol abuse. Brief intervention, directed to the client, involves motivational discussion focused on raising the client’s awareness of their substance use and its consequences, and motivated them toward behavioral change. Successful brief intervention encompasses support of the client’s empowerment to make behavioral changes. A client found to have a moderate risk for substance or alcohol abuse should be referred for brief treatment of up to three sessions. Upon determination that the client has a severe risk for substance or alcohol abuse, the client should also be referred for more extensive treatment to the appropriate chemical dependency treatment center or outpatient behavioral health provider. If the client is currently under the care of a behavioral health provider, the client must be referred back to that provider.

SBERT documentation for the first session must include:
• The client has an alcohol or drug-related traumatic injury or condition.
• Positive screening by a standardized screening tool.
• Laboratory results such as blood alcohol content, toxicology screen, or other measures showing at least a moderate risk for alcohol or substance abuse.
• The name, address, and telephone number of the provider to which the client is referred, if a referral is made.

The provider who performed the screening must document that a follow-up appointment was made for a subsequent session.

4.3 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including hospital services. Hospital services are subject to retrospective review and recoupment if documentation does not support the service that was submitted for reimbursement.

4.4 Outpatient Utilization Review
UR activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or TEFRA are required by Title XIX of the Social Security Act, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need, of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to UR monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of Texas Medicaid.

TMHP is responsible for a comprehensive integrated review process to identify misuse and inappropriate claim submission patterns by outpatient hospitals and HASCs. All providers are subject to TMHP’s UR monitoring. Providers are selected for review based on a comparison of their individual resource utilization with a peer group of similar specialty and geographic locality. The main goal of the required utilization control is to identify those providers whose practice patterns are aberrant from their peers and provide the necessary educational actions to help the provider achieve Texas Medicaid compliance. An analysis of UR data is completed by a registered nurse analyst for review by the medical director and staff. If the analyst substantiates that a provider’s practice and claim submission patterns are inconsistent with the federal requirements and Texas Medicaid’s scope of benefits, a TMHP repre-
sentative contacts the provider. The purpose of the contact is to discuss appropriate claim submission guidelines and to assist the provider in resolving the inappropriate claim submission patterns identified in the review.

TMHP uses the following criteria when reviewing all hospital outpatient medical records. Services must be:

- Medically necessary.
- Ordered by a physician, signed, and dated. Signature stamps are valid if initialed and dated by the physician.
- Submitted in the quantities ordered and documented as provided.
- Program benefits.
- Specifically identified on the charge tickets or itemized statement submitted with the claim or by the HCPCS procedure code on the claim.
- Indicated by the documentation in the medical record.
- Submitted to Texas Medicaid only after other medical insurance resources have been exhausted.


The determination of the TMHP UR process may result in the following:

- Educational letters and visits
- Mail-in of medical records for review
- On-site medical record review (outpatient, HASC, or inpatient records not reviewed)
- Referral of questionable claims to HHSC or HHSC OIG
- Recoupment
- Prepayment review

The intent of these actions is to ensure the most effective and appropriate use of available services and facilities and provide appropriate, cost-effective care to clients with Medicaid coverage.

4.5 Claims Filing and Reimbursement

4.5.1 Outpatient Claims Information

Claims for scheduled procedures that are performed in a HASC must be submitted using the HASC provider identifier with type of bill (TOB) 131. Claims for emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted using the hospital provider identifier and appropriate revenue and HCPCS code (if required) with TOB 131.

Claims for outpatient hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form.

Freestanding ambulatory surgical centers must submit claims on the CMS-1500 claim form. The performing surgeon or referring physician name and number must be identified in Block 17. Identification of outpatient charges must be in Block 44 if submitting by HCPCS code. If appropriate, the revenue code must be indicated in Block 42. Texas Medicaid recommends the use of specific procedure codes for claim submission. Do not use the revenue code description in Block 43; the HCPCS narrative description must be identified in this block. For example, when submitting charges for physical therapy, do not use the description associated with revenue code 420. To receive reimbursement for physical therapy services, providers must identify the specific modality used (e.g., gait training).
Examples:

- **Emergency Room.** Submit as “Emergency room” or “Emergency room charge per use.” If the client visits the emergency room more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code. Claims for emergency CT, CTA, MRI, or MRA studies provided in the emergency department must have the appropriate corresponding emergency services revenue code (450, 451, 456, or 459) to be considered for payment.

- **Observation Room.** Submit as “observation room.” (Revenue code 762).

- **Operating Room.** Submit as “Operating Room.” (Revenue code 360, 361, or 369).

- **Recovery Room.** Submit as “Recovery Room” or “Cast Room” as appropriate. (Revenue code 710 or 719).

- **Injections.** Must have “Inj.-name of drug; route of administration; the dosage and quantity” or the injection code.

- **Drugs and Supplies.** The drug description must include the name, strength, and quantity. Take-home drugs and supplies are not a benefit of Texas Medicaid:
  - Take-home drugs must be submitted with revenue code 253.
  - Take-home supplies must be submitted with revenue code 273.
  - Self-administered drugs must be submitted with revenue code 637.

- **Radiology.** Facilities must submit claims using the most appropriate revenue and HCPCS code. The physician must submit claims for professional services by a physician separately. The license number of the ordering physician must be in Block 83. If the client receives the same radiology procedure more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (such as 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.

- **Laboratory.** Provide a complete description or use the procedure codes for the laboratory procedures. The physician must submit claims for professional services by a physician separately. Blocks 78–79 must have the license number of the ordering physician. If laboratory work is sent out, enter the name of the test and name and address or Medicaid number of the laboratory where the work was forwarded. If the client receives the same laboratory procedure more than once in one day, give the time for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.

- **Nuclear Medicine.** Provide a complete description.

- **Day Surgery.** Day surgery must be submitted as an inclusive charge using TOS F. Providers must not submit claims for separate services that were provided in conjunction with the surgery (e.g., lab, radiology, and anesthesia). File claims for unscheduled emergency outpatient surgical procedures with separate charges (e.g., lab, radiology, anesthesia, and emergency room) for all services using TOB 131 and the hospital’s provider identifier.

Claims for emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted using the hospital provider identifier and appropriate revenue and HCPCS code (if required) with TOB 131.

Refer to the ASC/HASC section for information on scheduled procedures. Additional claims information can be found within individual topic areas within this section.
Charges on claims must be itemized on the face of the UB-04 CMS-1450 paper claim form instead of submitting attachments or charge details. TMHP uses information attached to the claim for clarification purposes only.

**Note:** The UB-04 CMS-1450 paper claim form is limited to 28 items per outpatient claim. This limitation includes surgical procedures from Blocks 74 and 74a-e. If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims.

If a claim contains more than 28 details, continue the claim on additional UB-04 CMS-1450 paper claim forms. Total each claim form as a stand-alone claim. If you do not total each page, your claim may be denied for being over the limitation, and must be resubmitted with 28 or less details.

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. 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 Paper 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.

Outpatient hospital services must be itemized by date of service. Procedures repeated over a period of time must be submitted for each separate date of service. Do not combine multiple dates of service on the same line detail.

### 4.5.2 Outpatient Reimbursement

Outpatient services are reimbursed on a reasonable cost based on a percentage of the hospital’s most recent tentative Medicaid cost report settlement.

Reimbursement for outpatient hospital services for high-volume providers is 76.03 percent of allowable cost. For the remaining providers, reimbursement for outpatient hospital services is 72.27 percent of allowable cost. High-volume providers are eligible for additional payments on Texas Medicaid fee-for-service claims. A high-volume outpatient hospital provider is defined as one that was paid at least $200,000 during calendar year 2004.

All clinical laboratory services are reimbursed at a percentage of the prevailing charge. Hospitals that are identified by Medicare as sole community hospitals are reimbursed at a higher percentage of the prevailing charges for services that are provided to clients in the outpatient setting.

Clinical pathology consultations are also allowed for reimbursement.

**Refer to:** The HHSC Rate Analysis web page at www.hhsc.state.tx.us/rad/hospital-svcs/index.shtml for additional information about hospital reimbursement.

Subsection 3.6.4, “Provider Cost and Reporting,” in this handbook for more information about the calculation of the interim rate.

4.5.3 Provider Cost and Reporting

Refer to: Subsection 3.6.4, “Provider Cost and Reporting,” in this handbook.

4.5.4 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to National Correct Coding Initiative (NCCI) relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

4.5.5 Outpatient Hospital Revenue Codes

UB-04 CMS-1450 revenue codes must be used to submit claims for outpatient hospital facility services. In some instances, a HCPCS procedure code is required in addition to the revenue code for accurate claims processing:

<table>
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<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
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<td>Special Charges – Canceled Surgery</td>
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<tr>
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<tr>
<td>256</td>
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<td>Prosthetic/orthotic devices</td>
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<td>Revenue Code</td>
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<td>Medical/surgical supplies and devices- other implants</td>
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<td><strong>Anesthesia</strong></td>
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<td>382</td>
<td>Blood- whole blood</td>
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<td>Blood- plasma</td>
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<td>Blood- platelets</td>
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<td>Blood- leuocytes</td>
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<td>Other blood storage and processing</td>
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<td>Respiratory services</td>
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<td>431</td>
<td>Occupational therapy- visit charge</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>432</td>
<td>Occupational therapy- hourly</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>433</td>
<td>Occupational therapy- group rate</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>434</td>
<td>Occupational therapy- evaluation/reevaluation</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>439</td>
<td>Occupational therapy- other</td>
<td>Procedure code required</td>
</tr>
<tr>
<td></td>
<td><strong>Speech-Language Pathology</strong></td>
<td></td>
</tr>
<tr>
<td>440</td>
<td>Speech-language pathology</td>
<td></td>
</tr>
<tr>
<td>441</td>
<td>Speech-language pathology- visit charge</td>
<td>Procedure code required</td>
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<tr>
<td>442</td>
<td>Speech-language pathology- hourly charge</td>
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</tr>
<tr>
<td>443</td>
<td>Speech-language pathology- group rate</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>444</td>
<td>Speech-language pathology- evaluation/reevaluation</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>449</td>
<td>Speech-language pathology- other</td>
<td>Procedure code required</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency Room</strong></td>
<td></td>
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<tr>
<td>450</td>
<td>Emergency room</td>
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</tr>
<tr>
<td>451</td>
<td>EMTALA emergency medical screening services</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>456</td>
<td>Urgent care</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>459</td>
<td>Other</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>460</td>
<td>Pulmonary function</td>
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</tr>
<tr>
<td>469</td>
<td>Pulmonary function- other</td>
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<tr>
<td></td>
<td><strong>Audiology</strong></td>
<td></td>
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<tr>
<td>470</td>
<td>Audiology</td>
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</tr>
<tr>
<td>471</td>
<td>Audiology- diagnostic</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>472</td>
<td>Audiology- treatment</td>
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</tr>
<tr>
<td>479</td>
<td>Audiology- other</td>
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<tr>
<td></td>
<td><strong>Cardiology</strong></td>
<td></td>
</tr>
<tr>
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<td>Cardiology</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>481</td>
<td>Cardiology- cardiac cath lab</td>
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</tr>
<tr>
<td>Revenue Code</td>
<td>Description</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>482</td>
<td>Cardiology- stress test</td>
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</tr>
<tr>
<td>483</td>
<td>Unassigned procedure code</td>
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</tr>
<tr>
<td>489</td>
<td>Cardiology- other</td>
<td>Procedure code required</td>
</tr>
<tr>
<td><strong>Clinic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>510</td>
<td>Clinic</td>
<td></td>
</tr>
<tr>
<td>511</td>
<td>Chronic pain center</td>
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<tr>
<td>512</td>
<td>Dental clinic</td>
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</tr>
<tr>
<td>513</td>
<td>Psychiatric clinic</td>
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</tr>
<tr>
<td>514</td>
<td>Obstetrics-Gynecology (OB/GYN) clinic</td>
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</tr>
<tr>
<td>515</td>
<td>Pediatric clinic</td>
<td></td>
</tr>
<tr>
<td>516</td>
<td>Urgent care clinic</td>
<td></td>
</tr>
<tr>
<td>517</td>
<td>Family practice clinic</td>
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</tr>
<tr>
<td>519</td>
<td>Other clinic</td>
<td></td>
</tr>
<tr>
<td><strong>Freestanding Clinic</strong></td>
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<td></td>
</tr>
<tr>
<td>520</td>
<td>Freestanding clinic</td>
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<tr>
<td>523</td>
<td>Family practice clinic</td>
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<tr>
<td>526</td>
<td>Urgent care clinic</td>
<td></td>
</tr>
<tr>
<td>529</td>
<td>Other freestanding clinic</td>
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</tr>
<tr>
<td><strong>Skilled Nursing (Home Health)</strong></td>
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<tr>
<td>550</td>
<td>Skilled nursing</td>
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<tr>
<td>551</td>
<td>Skilled nursing- visit charge</td>
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<td>552</td>
<td>Skilled nursing- hourly charge</td>
<td>Procedure code required</td>
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<tr>
<td>559</td>
<td>Skilled nursing- other</td>
<td>Procedure code required</td>
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<tr>
<td><strong>Medical Social Services (Home Health)</strong></td>
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<tr>
<td>560</td>
<td>Medical social services</td>
<td>Procedure code required</td>
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<tr>
<td>561</td>
<td>Medical social services- visit charge</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>562</td>
<td>Medical social services- hourly charge</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>569</td>
<td>Medical social services- other</td>
<td>Procedure code required</td>
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<tr>
<td><strong>Home Health Aide (Home Health)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>570</td>
<td>Home health aide</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>571</td>
<td>Home health aide- visit charge</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>572</td>
<td>Home health aide- hourly charge</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>579</td>
<td>Home health aide- other</td>
<td>Procedure code required</td>
</tr>
<tr>
<td><strong>Other Visits (Home Health)</strong></td>
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<td></td>
</tr>
<tr>
<td>580</td>
<td>Other visits (home health)</td>
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<td>581</td>
<td>Other visits (home health)- visit charge</td>
<td>Procedure code required</td>
</tr>
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<td>582</td>
<td>Other visits (home health)- hourly charge</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>589</td>
<td>Other visits (home health)- other</td>
<td>Procedure code required</td>
</tr>
<tr>
<td><strong>Magnetic Resonance Technology (MRT)</strong></td>
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<td></td>
</tr>
<tr>
<td>Revenue Code</td>
<td>Description</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>610</td>
<td>Magnetic resonance imaging- general classification</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>611</td>
<td>Magnetic resonance imaging- brain (incl brain stem)</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>612</td>
<td>Magnetic resonance imaging- spinal cord (incl spine)</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>619</td>
<td>Magnetic resonance imaging- other MRI</td>
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**Hospice Service**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>650</td>
<td>Hospice services</td>
</tr>
<tr>
<td>651</td>
<td>Routine home care</td>
</tr>
<tr>
<td>652</td>
<td>Continuous home care - 1/2 (at least 8 but less than 16 hrs care)</td>
</tr>
<tr>
<td>655</td>
<td>Inpatient respite care</td>
</tr>
<tr>
<td>656</td>
<td>General inpatient care/non-respite</td>
</tr>
<tr>
<td>657</td>
<td>Physician</td>
</tr>
<tr>
<td>659</td>
<td>Hospice services - other</td>
</tr>
</tbody>
</table>

**Cast Room**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>700</td>
<td>General classification</td>
</tr>
<tr>
<td>709</td>
<td>Other cast room</td>
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</tbody>
</table>

**Recovery Room**

<table>
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<tr>
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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>710</td>
<td>General classification</td>
</tr>
<tr>
<td>719</td>
<td>Other recovery room</td>
</tr>
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</table>

**Labor Room/Delivery**

<table>
<thead>
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<th>Description</th>
</tr>
</thead>
<tbody>
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<td>720</td>
<td>General classification</td>
</tr>
<tr>
<td>721</td>
<td>Labor</td>
</tr>
<tr>
<td>722</td>
<td>Delivery</td>
</tr>
<tr>
<td>723</td>
<td>Circumcision</td>
</tr>
<tr>
<td>724</td>
<td>Birthing center</td>
</tr>
<tr>
<td>729</td>
<td>Other labor room/delivery</td>
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</table>

**Electrocardiogram (EKG/ECG)**

<table>
<thead>
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<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>730</td>
<td>General classification</td>
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</tr>
<tr>
<td>731</td>
<td>Holter monitor</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>732</td>
<td>Telemetry</td>
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</tr>
<tr>
<td>739</td>
<td>Other EKG/ECG</td>
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</tbody>
</table>

**Electroencephalogram (EEG)**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
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<tr>
<td>740</td>
<td>General classification</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>741</td>
<td>Other EEG</td>
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</tbody>
</table>

**Gastrointestinal Services**

<table>
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<tr>
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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>750</td>
<td>General classification</td>
</tr>
<tr>
<td>759</td>
<td>Other gastrointestinal</td>
</tr>
</tbody>
</table>

**Treatment or Observation Room**
4.5.6 Third Party Liability

Hospitals and providers enrolled in Texas Medicaid are required to inform TMHP about circumstances that may result in third party liability for health-care claims. After receiving this information, TMHP pursues reimbursement from responsible third parties.

Hospitals and providers must mail or fax the Other Insurance Form for Health Insurance or the Tort Response Form for accidents to the following address:

Texas Medicaid & Healthcare Partnership
TPL Correspondence
Third Party Liability Unit PO Box 202948
Austin, TX 78720-2948
Fax: (512) 514-4225
5. AMBULATORY SURGICAL CENTER AND HOSPITAL AMBULATORY SURGICAL CENTER

5.1 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 HASC 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.

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

The Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

5.2 Services, Benefits, Limitations, and Prior Authorization
ASCs, both freestanding and hospital-based, provide same day elective surgery for clients who do not require a hospital admission and who are not expected to require extensive postoperative care.

5.2.1 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.

Refer to: Subsection 2.2.3, “Medical Supplies,” in the Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks).
5.2.2 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 prior to anesthesia administration
- Modifier 74 for a discontinued outpatient procedure after anesthesia administration
- At least one of the following diagnosis codes: V641, V642, or V643

Claims that are submitted with diagnosis code V641, V642, or V643 or with modifier 73 or 74 are suspended for review of the medical documentation that was 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.

5.2.3 Complications Following Day Surgery Requiring Outpatient Observation or Inpatient Admission

If the client is placed in outpatient observation or inpatient status following an HASC day surgery, the day surgery procedure must still be submitted as an outpatient procedure under the HASC provider identifier.

Refer to: Subsection 4.2.3.2, “Complications Following Elective or Scheduled Day Surgeries,” and Subsection 4.2.3.4, “Emergency or Unscheduled Day Surgeries,” in this handbook.

5.2.4 Planned Admission for Day Surgery

Inpatients may occasionally require a surgery that has been designated as an outpatient procedure. The physician must document the need for this surgery as an inpatient procedure before the procedure is performed. These claims are subject to retrospective review.

5.2.5 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.


5.2.6 Colorectal Cancer Screening

Procedure codes G0104 and G0105 are benefits of Texas Medicaid in the ASC or HASC setting.
Procedure code G0104 is limited to diagnosis codes V1090, V1272, V700, V7650, V7651, or V7652.
Procedure code G0105 is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5550</td>
</tr>
<tr>
<td>55841</td>
</tr>
</tbody>
</table>

Authorization is not required for colorectal cancer screening.


5.2.7 Dental Therapy Under General Anesthesia
Facilities must use procedure code 41899 with modifier EP to submit claims for dental therapy under general anesthesia. Prior authorization is not required for ASCs and HASCs unless the client is enrolled in a Medicaid managed care organization.

Refer to: in the Children’s Services Handbook (Vol. 2, Provider Handbooks).

5.2.8 Fluocinolone Acetonide
Procedure code 67027 for implantation may be reimbursed to HASCs. This benefit is limited to clients who are 12 years of age and older and requires prior authorization.


5.2.9 Implantable Infusion Pumps
Procedure codes E0782, E0783, and E0786 are a benefit of Texas Medicaid if a medical necessity exists. Implantable infusion pumps may be medically necessary in the following circumstances:

An IIP is not a benefit for the following uses:
- Continuous insulin infusion for diabetes
- Continuous heparin infusion for recurrent thromboembolic disease
- Continuous intralvesional infusion for severe chronic intractable pain
- Continuous intra-arterial infusion
- Continuous intra-articular infusion for severe chronic intractable pain
- Administration of antibiotics for osteomyelitis

All supplies associated with an IIP are included with the reimbursement for the surgery to implant the infusion pump and are not reimbursed separately.

Procedure codes E0782, E0783, and E0786 may be reimbursed separately from the global fee. Prior authorization requests for implantable infusion pumps must be submitted to the Special Medical Prior Authorization Department.

5.2.9.1 Prior Authorization for Implantable Infusion Pump

Providers must request prior authorization for the implantable infusion pump through the SMPA department with the supporting documentation for medical necessity. Send authorization requests to:

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

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.


5.2.10 Stereotactic Radiosurgery

Procedure codes 61795 and S8030 are payable to ASC and HASC facilities. Prior authorization is required.

Refer to: Subsection 8.2.64.3, “Stereotactic Radiosurgery,” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2 Provider Handbooks).

5.2.11 Brachytherapy

The following procedure codes are payable to ASC and HASC facilities:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>19296</td>
</tr>
<tr>
<td>92974</td>
</tr>
</tbody>
</table>

Prior authorization is not required for brachytherapy services.

Refer to: Subsection 8.2.64, “Radiation Therapy,” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2 Provider Handbooks).

5.2.12 Neurostimulators

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


Neurostimulator devices may be reimbursed separately from the global fee.

Refer to: The Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for procedure codes that may be reimbursed to ASC providers.

5.2.13 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: (512) 514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.
### 5.3 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 submitted for reimbursement.

### 5.4 Claims Filing and Reimbursement

#### 5.4.1 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 must submit claims to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form.

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 paper 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 paper claim forms from the vendor of their choice. TMHP does not supply them.

Scheduled procedures performed in a HASC must be submitted for reimbursement using the HASC provider identifier with TOB 131. Emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted for reimbursement using the hospital provider identifier with TOB 31.

To submit claims for services performed by certified registered nurse anesthetists (CRNAs), an ASC must enroll as a CRNA group provider and indicate the CRNA performing provider identifier on claims for those services.

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


#### 5.4.2 Reimbursement

Reimbursement of ASC and HASC procedures is based on the CMS-approved Ambulatory Surgical Code Groupings (1 through 9 per CMS and Group 10 per HHSC) payment schedule. Reimbursement is limited to the lesser of the amount reimbursed to an ASC for similar services, the hospital’s actual charge, or the allowable cost determined by HHSC. 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.

Claims for physician and CRNA services performed in an ASC or HASC must be submitted under the physician or CRNA provider identifier and are reimbursed separately.

#### 5.4.2.1 ASC and HASC Global Services

The ASC or HASC payment represents a global payment and includes room charges and supplies. Covered services provided are submitted 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 submitted 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 submitted separately with documentation that the complicating condition arose after the initiation of the surgery.

Medical and prosthetic devices such as intraocular lenses may be supplied by the ASC or HASC and implanted, inserted, or otherwise applied during a covered surgical procedure and is considered part of the global surgical fee.

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

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

Subsection 4.2.3, “Day Surgery,” in this handbook for information about HASCs.

### 5.4.2.2 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

### 6. MILITARY HOSPITALS

#### 6.1 Military Hospital Enrollment

To enroll in Texas Medicaid, a military hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Veterans Administration (VA) hospitals are eligible to receive Texas Medicaid payment only on claims that have crossed over from Medicare.

Military hospital providers must comply with CLIA rules and regulations. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

#### 6.2 Services, Benefits, Limitations and Prior Authorization

##### 6.2.1 Military Hospital Inpatient Services

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Reimbursement to hospitals for inpatient services is limited to the Medicaid “spell of illness.” The *spell of illness* is defined as “30 days of inpatient hospital care, which may accrue intermittently or consecutively.”

After 30 days of inpatient care have been provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. Exceptions are made in the following instances:

- THSteps-eligible clients do not have a 30-day spell of illness limitation, if medically necessary conditions exist (covered under THSteps-CCP).
Refer to: The Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).


Hospitals may submit information only claims to TMHP when one of the following situations exists:

- The inpatient 30-day spell of illness benefit is exhausted.
- Payment that was made by a third party resource or other insurance exceeds the Medicaid allowed amount.

For clients who are 21 years of age and older, there is an inpatient expenditure cap of $200,000 per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments exceeding $200,000 will be recouped.

It is appropriate to submit information only claims using TOB 110.

The following hospital services must be medically necessary and are subject to the utilization review requirements of Texas Medicaid. Medicaid reimbursement for services cannot exceed the limitations of Texas Medicaid.

Inpatient hospital services include the following items and services:

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit, including meals, special diets, and general nursing services; or an allowance for bed and board in private accommodations, including meals, special diets, and general nursing services up to the hospital’s charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations are provided in full if required for medical reasons, as certified by the physician. Additionally, the hospital must document the medical necessity for a private room, such as the existence of a critical or contagious illness or a condition that could result in disturbance to other patients. This type of information is included in Block 80 or attached to the claim.
- Whole blood and packed red cells that are reasonable and necessary for treatment of illness or injury, provided they are not available without cost.
- All medically necessary services or supplies ordered by a physician.

Medicaid benefits are not available for take-home or self-administered drugs or personal comfort items except when received by prescription through the VDP.

Only inpatient claims that have an emergency diagnosis on the claim are considered for reimbursement.

6.2.2 Military Hospital Outpatient and Physician Services

Although Medicare reimburses for emergency outpatient and inpatient services, Medicaid does not reimburse for either outpatient or physician services. Military hospitals are not reimbursed for outpatient day surgery.

6.2.3 Prior Authorization

Prior authorization is not required for services rendered in military hospitals.

6.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including military hospital services. Military hospital services are subject to retrospective review and recoupment if documentation does not support the service submitted for reimbursement.

6.3.1 Documentation for Nursing Facility Admissions

The admission Minimum Data Set (MDS) must be used for admissions to a nursing facility. There are instances in which hospital social workers and discharge nurses might also complete the admission MDS, such as:
• If the client is in a long-term care acute center.
• If the potential receiving nursing facility wants a better clinical picture of the client, a paper copy of
  the admission MDS is completed by the hospital staff before the client is accepted for admission into
  the nursing facility.

Refer to: The Long Term Care Program’s page on the TMHP website at www.tmhp.com for
additional information, including instructions for all forms and assessments.

6.4 Claims Filing and Reimbursement

6.4.1 Military Hospital Claims Information

If TOB 110 is used to submit a claim, all charges must be noncovered and the claim will finalize with
EOB 217, “Payment reduced through hospital action.”

It is appropriate to submit information only claims using TOB 110.

Military hospitals may submit total charges in one line with appropriate accommodation revenue codes.
Emergency hospital services must be submitted to TMHP in an approved electronic format or on the
UB-04 CMS-1450 paper claim form. Providers may purchase claim forms from the vendor of their
choice. TMHP does not supply the forms.

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

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

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 state-
ments, are not accepted as claims supplements.

Refer to: Subsection 6.6, “UB-04 CMS-1450 Paper Claim Filing Instructions,” in Section 6, “Claims
Filing” (Vol. 1, General Information) for paper claims completion instructions. Blocks that
are not referenced are not required for processing by TMHP and may be left blank.

Form HS.14, “Military Hospital (Emergency Inpatient)” in this handbook.

6.4.2 Military Hospital Reimbursement

Reimbursement is limited to claims submitted for emergency inpatient care only.

Allowed inpatient hospital stays are reimbursed according to a prospective payment methodology based
on DRGs. The reimbursement method itself does not affect inpatient benefits and limitations. Texas
Medicaid requires that one claim be submitted for each inpatient stay with appropriate diagnosis and
procedure code sequencing. Providers must submit only one claim per inpatient stay to Medicaid,
regardless of the diagnosis, to ensure accurate payment. The DRG reimbursement includes all facility
services provided to the client while registered as an inpatient.

Reimbursement to hospitals for inpatient services is limited to $200,000 per client, per benefit year
(November 1 through October 31). This limitation does not apply to services related to certain organ
transplants or services to clients who are 20 years of age and younger and covered by the CCP.

Military hospitals should keep a Medicaid client as an inpatient for only the length of time necessary to
stabilize the client. The Medicaid client, once stabilized, should be transferred to the nearest Medicaid
acute care hospital facility for further treatment.

When more than one hospital provides care for the same client, the hospital that furnishes the most
significant amount of care receives consideration for a full DRG payment.
The other hospital is paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility.

Client transfers within the same facility or readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are considered one continuous stay. These readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Texas Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be included in one submission under the provider identifier. Admissions that were submitted inappropriately are identified and denied during the utilization review process and may result in an intensified review.

After all hospital claims have been submitted, TMHP performs a post-payment review to determine if the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

The inpatient DRG reimbursement includes payment for all radiology and laboratory services, including those sent to referral laboratories.

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

7. CLAIMS RESOURCES

Refer to the following sections and forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix D: * Acronym Dictionary</td>
<td>Appendix D (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
</tr>
<tr>
<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Hospital Inpatient Claim Form Example</td>
<td>Form HS.13, Section 9 of this handbook</td>
</tr>
<tr>
<td>Hospital-Based ASC Claim Form Example</td>
<td>Form HS.12, Section 9 of this handbook</td>
</tr>
<tr>
<td>Hospital Report (Newborn Child or Children) (Form 7484)</td>
<td>Form HS.1, Section 9 of this handbook</td>
</tr>
<tr>
<td>Hospital-Based ASC Claim Form Example</td>
<td>Form HS.12, Section 9 of this handbook</td>
</tr>
<tr>
<td>Military Hospital (Emergency Inpatient) Claim Form Example</td>
<td>Form HS.14, Section 9 of this handbook</td>
</tr>
<tr>
<td>Sterilization Consent Form (English)</td>
<td>Form HS.9, Section 9 of this handbook</td>
</tr>
<tr>
<td>Sterilization Consent Form (Spanish)</td>
<td>Form HS.10, Section 9 of this handbook</td>
</tr>
<tr>
<td>Sterilization Consent Form Instructions (2 Pages)</td>
<td>Form HS.8, Section 9 of this handbook</td>
</tr>
<tr>
<td>Appendix A: 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>Section 3: TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>UB-04 CMS-1450 Paper Claim Filing Instructions</td>
<td>Subsection 6.6 (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>
8. CONTACT TMHP

*Note:* 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
HS.1 Hospital 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

PURPOSE: This form is to be used by HOSPITALS ONLY to report the birth of a child of a mother currently eligible under the Texas 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 Recipient number of the newborn child, please complete this document and submit it to 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.

Has the mother relinquished her rights to the newborn child? □ Yes □ No
If “Yes,” give date of relinquishment ________________________________

(Handwritten)

Child’s Attending Physician

Hospital Name

Hospital Address—Street

City, State, ZIP

Physician’s Medical License No.

Completed By (please type or print)

Date Form Mailed

( )
HS.2  Hysterectomy Acknowledgment Form

MEDICAID CLIENT IDENTIFICATION NUMBER  / / / / / / / / /

Hysterectomy Acknowledgment

I hereby acknowledge that I was, prior to surgery ________________ (month, day, year), informed both orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom that procedure is performed permanently incapable of bearing children.

________________________________________ __________________
Signature of Client or Designated Representative Date

Reconocimiento

Yo afirmo haber sido informada verbalmente y por escrito, antes de la cirugía ______________________ (mes, día, año) que una histerectomía (extracción quirúrgica del útero) dejará a la persona a la cual se haya operado permanentemente, incapaz de tener hijos.

________________________________________ ___________________
Firma del Cliente o Representante Designado Fecha

Interpreter’s Statement

To be used if an interpreter is provided to assist the individual having the hysterectomy.

I have translated to the individual having a hysterectomy the information and advice presented orally by the individual obtaining consent. I have also read the consent form to ______________________ in ______________ language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

________________________________________ __________________
Signature of Interpreter Date

Revised 8/22/95
**Non-emergency Ambulance Prior Authorization Request**

<table>
<thead>
<tr>
<th>Requesting Provider</th>
<th></th>
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<tbody>
<tr>
<td>Name:</td>
<td></td>
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<tr>
<td>Provider TPI:</td>
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<tr>
<td>NPI:</td>
<td></td>
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<tr>
<td>Taxonomy:</td>
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<tr>
<td>Contact Name:</td>
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<tr>
<td>Phone:</td>
<td></td>
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<tr>
<td>Fax:</td>
<td></td>
</tr>
<tr>
<td>Ambulance Provider Name:</td>
<td></td>
</tr>
<tr>
<td>Ambulance Provider Identifier:</td>
<td></td>
</tr>
</tbody>
</table>

**Client Information**

Last Name: __________________________ First Name: __________________________ MI: ______

DOB: __ __/ __ __/ __ __ __ __ Client Medicaid/CSHCN Number: __________________________

**Client’s Current Condition Affecting Transport**

Diagnoses affecting transport: __________________________________________________________

*(Check each applicable condition)*

- □ Client requires monitoring by trained staff because
  - □ Oxygen
  - □ Airway
  - □ Suction
  - □ Cardiac
  - □ Comatose
  - □ Life support
- □ Ventilator dependent
- □ Poses immediate danger to self or others
- □ Continuous IV therapy or parenteral feedings *

* Provide additional detail (i.e. type of seizure or IV therapy, body part affected, supports needed, or time period for the condition), or provide detail of the client’s other conditions requiring transport by ambulance.

- □ Physical restraint or chemical sedation *
- □ Decreased level of consciousness *
- □ Isolation precautions (VRE, MRSA, etc.) *
- □ Wound precautions *
- □ Advanced decubitus ulcers *
- □ Contractures limiting mobility *
- □ Must remain immobile (i.e., fracture, etc.) *
- □ Decreased sitting tolerance time or balance *
- □ Active Seizures *

**Reason for Transport**

Hospital discharge? □ Yes □ No  
If yes, expected transport time: ______________

Other purpose: __________________________________________________________

Origin: __________________________ Destination: __________________________

Method of Transport: □ Ground □ Fixed Wing □ Helicopter □ Specialized Vehicle

**Request Type**

- □ One Time, Non-repeating Medicaid, CSHCN or Medicare
- □ Short Term (2 - 60 days) Medicaid, CSHCN or Medicare *
  - Begin Date: __ __/ __ __/ __ __ __ __
- □ Long Term (61 - 180 days) Medicaid and CSHCN Only *
  - End Date: __ __/ __ __/ __ __ __ __

* Physician signature required for Short Term and Long Term

**Certification**: I certify that the information supplied in this document constitutes true, accurate, and complete information and is supported in the medical record of the patient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and / or state law which can result in fines or imprisonment, in addition to recoupment of funds paid and administrative sanctions authorized by law.

Name: __________________________ Title: __________________________ Provider Identifier: __________________________

Signature: __________________________ Date Signed: __ __/ __ __/ __ __ __ __

Effective Date_09012012/Revised Date_10092012
Provider Instructions for Non-emergency Ambulance Prior Authorization Request Form

All non-emergency ambulance transportation must be medically necessary. Texas Medicaid, CSHCN Services Program, and Medicare have similar requirements for this service to qualify for reimbursement. This form is intended to accommodate all of the programs' requirements. The criteria for determining medical necessity include: the client is bed-confined and other methods of transportation are contraindicated, or the client's condition is such that transportation by ambulance is medically required. For additional information and changes to this policy and process refer to the respective program information: Texas Medicaid’s Provider Procedures Manual, CSHCN Services Program Provider Manual, and Banner Messages; and to Medicare’s manuals, newsletters and other publications.

1. Request Date—Enter the date the form is submitted.

2. Requesting Provider Information—Enter the name of the entity requesting authorization. (i.e., hospital, nursing facility, dialysis facility, physician).

3. Requesting Provider Identifiers—Enter the following information for the requesting provider (facility or physician):
   - Enter the Texas Provider Identifier (TPI) number.
   - Enter the National Provider Identifier (NPI) number. An NPI is a ten-digit number issued by the National Plan and Provider Enumeration System (NPPES).
   - Enter the primary national taxonomy code. This is a ten-digit code associated with your provider type and specialty. Taxonomy codes can be obtained from the Washington Publishing Company website at www.wpc-edi.com.

4. Ambulance Provider Identifier—Enter the TPI or NPI number of the requested ambulance provider. If the ambulance provider changes from the provider you originally requested, notify TMHP of the new provider by phone (1-800-540-0694, Option 3) or fax (1-512-514-4205).

5. Client’s Current Condition—This section must be filled out to indicate the client’s current condition and not to list all historical diagnoses. Do not submit a list of the client’s diagnoses unless the diagnoses are relevant to transport (i.e., if client has a diagnosis of hip fracture, the date the fracture was sustained must be included in documentation). It must be clear to TMHP when reviewing the request form, exactly why the client requires transport by ambulance and cannot be safely transported by any other means.

6. Isolation Precautions—Vancomycin-Resistant Enterococci (VRE) and Methicillin-Resistant Staphylococcus Aureus (MRSA) are just two examples of isolation precautions. Please indicate in the notes exactly what type of precaution is indicated.

7. Details for Checked Boxes—For each checked answer, a detailed explanation is required (i.e., if contractures is checked, please give the location and degree of contracture[s]). If a client has a decreased tolerance for sitting time, please indicate why the client has a decreased tolerance as well as the maximum length of time the client is able to sit upright. Additional documentation can be submitted with this request form if needed.

8. Request Type—Check the box for the request type. A One Time, non-repeating request is for a one day period. A Short Term request is for a period of 2-60 days when repeated transports are expected to occur; Medicaid, CSHCN Services Program, and Medicare permit short term requests. A Long Term request is for a period of 61-180 days when repeated transports are expected to occur; Medicare does not permit a Long Term request. Medicaid and CSHCN Services Programs require a physician signature for Short Term and Long Term requests. Enter the begin and end dates of the authorization period for short and long term requests.

9. Transport Time—This field must be filled out for all hospital discharge requests. The anticipated time of transport must be entered in order to ensure the request was initiated prior to the actual time of transport.

10. Name of Person Signing the Request—All request forms require a signature, date, and title of the person signing the form. A One Time request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner with knowledge of the client’s condition. A request of a Short Term or Long Term authorization period must be signed and dated by the physician. The signature must be dated not earlier than the 60th day before the date on which the request for authorization is made.

11. Signing Provider Identifier—This field is for the TPI or NPI number of the requesting facility or provider signing the form. The signature must be dated no earlier than 60 days prior to the transport.
### I. Identifying Information

<table>
<thead>
<tr>
<th>Medicaid Number:</th>
<th>Date: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name</td>
<td>Last:</td>
</tr>
<tr>
<td></td>
<td>First:</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>/ /</td>
</tr>
<tr>
<td>Age:</td>
<td>Sex:</td>
</tr>
<tr>
<td>Date of admission:</td>
<td>/ /</td>
</tr>
<tr>
<td>Time:</td>
<td></td>
</tr>
</tbody>
</table>

### Facility Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Contact Person:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
<tr>
<td>Taxonomy:</td>
<td>Benefit Code:</td>
</tr>
<tr>
<td>Commitment Type:</td>
<td>Effective Date: / /</td>
</tr>
<tr>
<td></td>
<td>County:</td>
</tr>
<tr>
<td></td>
<td>Judge:</td>
</tr>
</tbody>
</table>

| Referral source:          | □ Admitting MD  |
|                          | □ MH Professional |
|                          | □ Other (list):  |
| Current living arrangements: | □ With parent(s) |
|                            | □ Group/foster home |
|                            | □ Other (list):   |

### IIA. Primary symptom described in “specific observable behavior” that requires acute hospital care

(Include: precipitating events leading to admission)

### IIB. Other relevant clinical information, including inability to benefit from less restrictive setting

(Attach additional pages or documents, as necessary)

### IIC. Psychiatric medications

(include total daily doses)

<table>
<thead>
<tr>
<th>Name of chemical</th>
<th>Current use?</th>
</tr>
</thead>
</table>

### IID. Present and past drug/alcohol usage:

<table>
<thead>
<tr>
<th>Name of chemical</th>
<th>Current use?</th>
</tr>
</thead>
</table>

### IIE. Past psychiatric treatment

1. Number of previous inpatient admissions: [ ]
2. Previous ambulatory/outpatient treatment (provider or facility, frequency) – If none, why:

### III. Current diagnosis (Axis I):

### IV. Additional diagnosis (Axis I and Axis II):

### V. Current functional assessment scores (DSM IV):

| GAF [ ] |

### VI. No. of hospital days requested:

| Dates: / / to / / |

### VII. Aftercare plan:

<table>
<thead>
<tr>
<th>Provider or Facility:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Frequency:</th>
<th>Date: / /</th>
</tr>
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<table>
<thead>
<tr>
<th>Signature (attending MD):</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Print name:</th>
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</table>

<table>
<thead>
<tr>
<th>Provider license number</th>
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<table>
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<tr>
<th>Provider TPI:</th>
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<table>
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<tr>
<th>Provider NPI:</th>
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</table>

Effective Date_07302007/Revised Date_07102007
## I. Identifying Information

<table>
<thead>
<tr>
<th>Medicaid Number:</th>
<th>Date: / /</th>
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<tbody>
<tr>
<td>Client Name</td>
<td>Date: / /</td>
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<td>Last:</td>
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<td>Age:</td>
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<td></td>
<td>Sex:</td>
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<tr>
<td></td>
<td>Date of admission: / /</td>
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</tbody>
</table>

### Facility Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Contact Person:</th>
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<td>Benefit Code:</td>
</tr>
<tr>
<td>Commitment Type:</td>
<td>Effective Date: / /</td>
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<tr>
<td>(If applicable)</td>
<td>County:</td>
</tr>
<tr>
<td></td>
<td>Judge:</td>
</tr>
</tbody>
</table>

## IIA. Current status of primary symptoms that require continued acute hospital care

(Include: 1. Date of most recent occurrence; 2. Frequency; 3. Duration; 4. Severity)

## IIB. Other relevant clinical/diagnostic information about the patient from the past 72 hours

(Attach additional pages or documents, as necessary)

## IIC. Current psychiatric medication

(include total daily doses)

### IID. Discharge criteria

1.

2.

3.

## IIE. Describe treatment, contacts, plans (including outcome) with family, school, etc.

## III. Current diagnosis (Axis I):

## IV. Additional diagnosis (Axis I and Axis II):

## V. Current functional assessment scores (DSM IV): GAF [ ]

## VI. No. of hospital days requested: [ ]

| Dates: / / to / / |

## VII. Aftercare plan:

Provider or Facility:

Frequency:

Signature (attending MD): Date: / /  

Print name: Provider license number

Provider TPI: Provider NPI:
## Radiology Prior Authorization Request Form

This form is used to obtain prior authorization for elective outpatient services or update an existing outpatient authorization. All fields marked with an asterisk (*) are required. The information in Section 2 is only required for updated or retroactive authorizations. Forms that are submitted without all of the required information will be returned for correction.

### Telephone number: 1-800-572-2116  Fax number: 1-800-572-2119  *Date of Request: / /

### Please check the appropriate action requested:

- [ ] CT Scan
- [ ] CTA Scan
- [ ] MRI Scan
- [ ] MRA Scan
- [ ] PET Scan
- [ ] Cardiac Nuclear Scan
- [ ] Update/change codes from original PA request

### Client Information

*Name:*

*Medicaid number:*

*Date of Birth: / /

### Facility Information

*Address:*

Reference number:

*TPI:*

*NPI:*

Taxonomy:  Benefit Code:

### Requesting/Referring Physician Information

*Name:*

*Address:*

*Telephone:*

*Fax number:*

*TPI:*

*NPI:*

Taxonomy:  Benefit Code:

### Section 1

**Service Types**

- [ ] Outpatient Service(s)
- [ ] Emergent/Urgent Procedure

**Date of Service:** / /

*Procedures Requested:*

**Diagnosis Codes**

*Primary:*

*Secondary:*

*Clinical documentation supporting medical necessity for a radiology procedure includes treatment history, treatment plan, medications, and previous imaging results:

*Requesting/Referring Physician (Signature Required):*

*Print Name:*

*Date: / /

### Section 2—Updated Information (when necessary)

**Date of Service:** / /

*Procedures Requested:*

**Diagnosis Codes**

*Primary:*

*Secondary:*

*Clinical documentation supporting medical necessity for a procedure code change includes treatment history, treatment plan, medications, and previous imaging results:

*Requesting/Referring Physician (signature required):*

*Print Name:*

*Date: / /

**Physician must complete and sign this form prior to requesting authorization.**

Requesting/Referring Physician License No.:

Requesting/Referring Physician TPI:

Effective Date: 02/2012  Revised Date: 10/01/2009
Sterilization Consent Form Instructions

Per Title 42 Code of Federal Regulations (CFR) 50, Subpart B, all sterilizations require a valid consent form regardless of the funding source. Ensure all required fields are completed for timely processing.

Fax or mail the Sterilization Consent Form five business days before submitting the associated claim(s) to expedite the processing of the Sterilization Consent Form and associated claim(s).

Fax fully completed Sterilization Consent Forms to Texas Medicaid & Healthcare Partnership (TMHP) at 1-512-514-4229. Claims and appeals are not accepted by fax. Only send family planning sterilization correspondence to this fax number.

Note: Hysterectomy Acknowledgment forms are not sterilization consents and should be faxed to 1-512-514-4218.

Clients must be at least 21 years of age when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the consent will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

There must be at least 30 days between the date the client signs the consent form and the date of surgery, with the following exceptions:

Exceptions: (1) Premature delivery - There must be at least 72 hours between the date of consent and the date of surgery. The informed consent must have been given at least 30 days before the expected date of delivery. (2) Emergency Abdominal Surgery - There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.

Listed below are field descriptions for the Sterilization Consent Form. Completion of all sections is required to validate the consent form, with only two exceptions:

Exceptions: Race and Ethnicity Designation is requested but not required. The Interpreter’s Statement is not required as long as the consent form is written in the client's language, or the person obtaining the consent speaks the client's language. If this section is partially completed, the consent will be denied for incomplete information.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation.

Required Fields
All of the fields must be legible in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter will not be accepted.

Consent to Sterilization
• Name of Doctor or Clinic.
• Name of the Sterilization Operation.
• Client’s Date of Birth (month, day, year).
• Client's Name (first and last names are required).
• Name of Doctor or Clinic.
• Name of the Sterilization Operation.
• Client’s Signature.
• Date of Client Signature - Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.
Interpreter’s Statement (If applicable)
• Name of Language Used by Interpreter.
• Interpreter’s Signature.
• Date of Interpreter’s Signature (month, day, year).

Statement of Person Obtaining Consent
• Client’s Name (first and last names are required).
• Name of the Sterilization Operation.
• Signature of Person Obtaining Consent - The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an original signature, not a rubber stamp.
• Date of the Person Obtaining Consent’s Signature (month, day, year) - Must be the same date as the client’s signature date.
• Facility Name - Clinic/office where the client received the sterilization information.
• Facility Address - Clinic/office where the client received the sterilization information.

Physician’s Statement
• Client’s Name (first and last names are required).
• Date of Sterilization Procedure (month, day, year) - Must be at least 30 days and no more than 180 days from the date of the client’s consent except in cases of premature delivery or emergency abdominal surgery.
• Name of the Sterilization Operation.
• Expected Date of Delivery (EDD) - Required when there are less than 30 days between the date of the client consent and date of surgery. Client’s signature date must be at least 30 days prior to EDD.
• Circumstances of Emergency Surgery - Operative report(s) detailing the need for emergency abdominal surgery are required.
• Physician’s Signature - Stamped or computer-generated signatures are not acceptable.
• Date of Physician’s Signature (month, day, year) - This date must be on or after the date of surgery.

Paperwork Reduction Act Statement
This is a required statement and must be included on every Sterilization Consent Form submitted.

Additional Required Fields
• Medicaid or Family Planning Number - Clients submitted as Titles V, X, and XX may not have a Family Planning number. Please simply indicate the appropriate Title below.
• Date Client Signed the Consent (month, day, year).
• The following provider identification numbers will be required to expedite the processing of the consent form:
  o TPI
  o NPI
  o Taxonomy
  o Benefit Code
• Provider/Clinic Phone Number.
• Provider/Clinic Fax Number (If available).
• Family Planning Title for Client - Indicate by circling V, X, XIX (Medicaid), or XX.

Effective Date_07/30/2007/Revised Date_03/10/2010
### Sterilization Consent Form (Fax Consent Form to 1-512-514-4229)

**Notice:** Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.

I have asked for and received information about sterilization from ______________________ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid if I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about these temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a ______________________ (specify type of operation). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (month), _____ (day), _____ (year). I, ______________________, hereby consent of my own free will to be sterilized by ______________________ (doctor or clinic) by a method called ______________________ (specify type of operation).

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

---

### Consent to Sterilization

**Client’s Signature:** [ ] **Date of Signature: / / (month/day/year)**

**Physician’s Statement:**

I informed the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

**Facility Name:**

**Facility Address:**

---

### Interpreter’s Statement

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice and presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ______________________ language and explained its contents to him/her. To the best of my knowledge and belief, he/she has understood this explanation.

**Interpreter’s Signature:** [ ] **Date of Signature: / / (month/day/year)**

---

### Statement of Person Obtaining Consent

**Before ______________________ (client’s full name), signed the consent form, I explained to him/her the nature of the sterilization operation ______________________ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.**

I informed the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

**Signature of Person Obtaining Consent:** [ ] **Date of Signature: / / (month/day/year)**

---

### Physician’s Statement (Fax Consent Form to 1-512-514-4229)

**Physician’s Signature:** [ ] **Date of Signature: / / (month/day/year)**

---

### Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0937-0166. The time required to complete this information collection is estimated to average 1 hour 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OIO/PRA, 200 Independence Ave., S.W., Suite 537-H, Washington D.C. 20020, Attention: PRA Reports Clearance Officer HHS-687
HS.10 Sterilization Consent Form (Spanish)

Sterilization Consent Form (Spanish)
(Fax Consent Form to 1-512-514-4229)

HS-10 Sterilization Consent Form (Spanish)

Declaración De La Persona Que Obtiene Consentimiento

Notas:

La decisión de no esterilizarse que usted puede tomar en cualquier momento, no causará el retiro o la retención de ningún beneficio que le sea proporcionado por programas o proyectos que reciben fondos federales.

Yo he solicitado y he recibido información de ___________________________ (especificar el tipo de operación). Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. He respondido satisfactoriamente a todas mis preguntas.

Entiendo que la esterilización se considera una operación permanente e irreversible. Yo he decidido que no quiero quedarme embarazada, no quiero tener hijos o no quiero procrear hijos. Me informaron sobre otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizado/a.

Entiendo que seré esterilizado/a por medio de una operación conocida como ___________________________ (especificar el tipo de operación). Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se llevará a cabo hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en la que firme esta Forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizado/a no resultará en la retirada de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.

Tengo por menos 21 años y nací el ______ (mes), ______ (día), ______ (año). Yo, ______________________________________ (médico o clínica) por el método llamado: ___________________________ (especificar el tipo de operación).

Mi consentimiento vence 180 días a partir de la fecha que aparece abajo con mi firma.

Tengo por lo menos 21 años de edad y nací el ______ (mes), ______ (día), ______ (año). Yo, ______________________________________ (médico o clínica) por el método llamado: ___________________________ (especificar el tipo de operación).

Declaración Del Intérprete

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada: He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizado/a por el individuo que ha obtenido este consentimiento. También le he leído a ella/él la Forma de Consentimiento en idioma y le he explicado el contenido de esta forma. A mi mejor saber y entender, ella/él ha entendido esta explicación.

Nombre del lugar: __________________________________________________________________________

Firma del médico: Fecha: / / (mes, día, año)

Declaración Sobre Ley De Reducción De Trámites

De acuerdo con la Ley de Reducción de Trámites de 1995, ninguna persona está obligada a responder a una solicitud de información a menos que muestre un número de control válido de OMB. El número de control válido de OMB para esta solicitud es 0937-0166. Se ha estimado que el tiempo promedio necesario para completar esta recolección de información es 1 hora y 15 minutos de respuesta, incluido el tiempo para revisar las instrucciones, buscar fuentes de información existente, reunir los datos necesarios y completar y revisar la recolección de información. Si tiene algún comentario sobre la exactitud del cálculo (s) del tiempo o sugerencias para mejorar esta forma, por favor escriba a: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 537-H, Washington D.C. 20201, Attention: PRA Reports Clearance Officer.

All Fields in This Box Required for Processing

TPI: NPI: Taxonomy:

Benefit Code: Provider/Clinic Telephone: Provider/Clinic Fax Number:

Titled Billed (check one): V ☐ X ☐ XIX(Medicaid) ☐ XX

Effective Date_05/01/2010/Revised Date_07/14/2010
10. CLAIM FORM EXAMPLES
**HEALTH INSURANCE CLAIM FORM**
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE</th>
<th>CHAMPUS</th>
<th>GROUP HEALTH PLAN</th>
<th>FECA</th>
<th>OTHER</th>
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<tr>
<td>(Medicare #)</td>
<td>(Medicaid #)</td>
<td>(Sponsor’s SSN)</td>
<td>(Member ID)</td>
<td>(SSN) or (SN)</td>
<td>(SSN) or (SN)</td>
<td>(SSN) or (SN)</td>
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<tr>
<th>2. PATIENT’S NAME (Last Name, First Name, Middle Initial)</th>
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<tr>
<td>Doe, Jane J.</td>
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<th>3. PATIENT’S BIRTH DATE</th>
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<tr>
<th>4. INSURED’S NAME (Last Name, First Name, Middle Initial)</th>
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<tbody>
<tr>
<td>Raquel Del Sol</td>
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<th>5. PATIENT’S ADDRESS (No., Street)</th>
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<tbody>
<tr>
<td>901 East Street, San Antonio, TX 77777</td>
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<th>6. PATIENT’S RELATIONSHIP TO INSURED</th>
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<th>7. INSURED’S ADDRESS (No., Street)</th>
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<tr>
<td>345 Morning Star, San Antonio, TX 77777</td>
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<th>8. INSURED’S NAME (Last Name, First Name, Middle Initial)</th>
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<td>Doe, Jane J.</td>
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<th>9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)</th>
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<th>10. IS PATIENT’S CONDITION RELATED TO:</th>
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<tr>
<td>a. EMPLOYMENT? (Current or Previous)</td>
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<td>b. AUTO ACCIDENT?</td>
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<tr>
<td>c. OTHER ACCIDENT?</td>
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<th>11. INSURED’S POLICY GROUP OR FECA NUMBER</th>
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<th>12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE</th>
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<tbody>
<tr>
<td>I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the undersigned physician or supplier for services described below.</td>
</tr>
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</table>

### Signature on File

**13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE:**

**14. DATE OF CURRENT:***

**15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.**

**16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION.**

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

**18. HOSPITALIZATION DATES RELATED TO CURRENT ILLNESS OR INJURY (Accident) OR ILLNESS (First symptom) OR DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line).**

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<th>PLACE OF SERVICE</th>
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<th>PHYSICIAN OR SUPPLIER INFORMATION</th>
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<th>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</th>
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<th>24. A. B. C. D. E.</th>
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<tr>
<td>3. 17a.</td>
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<th>25. A. B. C. D. E.</th>
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<td>4. 17b. NPI</td>
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<th>26. MEDICAID ADDRESS</th>
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<th>27. MEDICAID EIN</th>
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<th>28. PATIENT’S ACCOUNT NO.</th>
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<th>29. ACCEPT ASSIGNMENT?</th>
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<th>30. TOTAL CHARGE</th>
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<td>$750.00</td>
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<thead>
<tr>
<th>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</th>
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<tbody>
<tr>
<td>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</td>
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**Raquel Del Sol**

**32. SERVICE FACILITY LOCATION INFORMATION**

<table>
<thead>
<tr>
<th>33. BILLING PROVIDER INFO &amp; PH #</th>
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<tr>
<td>Del Rio Surgery Center</td>
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**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**

**NUCC Instruction Manual available at:** [www.nucc.org](http://www.nucc.org)
### HS.12 Hospital-Based ASC

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

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**VITAL INFORMATION**

- **NAME**: Doe, John  
- **ADDRESS**: 6789 Courtland Circle, Westville, TX 79065  
- **BIRTHDATE**: 12/16/1964  
- **GENDER**: M  
- **HOSPITAL**: Greatland Hospital Center  
- **ADDRESS**: 4004 Elm Loop, Westville, TX 512-555-1234

**GROUP INFORMATION**

- **INSURED**: Doe, John  
- **INSURED'S ID**: 123456789  
- **INSURED'S UNIQUE ID**: 123456789

**MEDICAL INFORMATION**

- **DATE OF SERVICE**: 01/01/2011  
- **SEQ CODE**: 1  
- **TOTAL CHARGES**: 871.87

---

**PROCEDURAL INFORMATION**

- **PROCEDURE**: Typano W/ masto and chain reconstruct  
- **PROCEDURE CODE**: F-69641  
- **PROCEDURE DATE**: 01/10/2011  
- **PROCEDURE AMOUNT**: 871.87

---

**FINANCIAL INFORMATION**

- **CPT**: 63403  
- **MEDICAID**: 9876543-21  
- **INSURED**: Medicaid

---

**REMARKS**

- **REMARKS**: Hearing Loss, Left Ear
# Hospital Inpatient

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**Total Charges**: 2620.44

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**医疗保险**:

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**Medicaid Insurance**: 1998 Alm Insurance

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**Remarks**: Pregnancy/Delivery.

Alm Insurance, 1 Maple Dr., Boston, MA 11211 denied 02/01/2004 for pre-existing condition.
**Military Hospital (Emergency Inpatient)**

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**UB-04 CMS-1450**

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|------------|---|-----|---|------|---|------|---|-----|---|-------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|---|-----------|
|            |   | M    | 01012009 | 04 | 1     | 7 | 08 | 05 |             |   |           |   | 01012009 |   |             |   |             |   |             |   |             |   |             |   |             |   |             |   |             |   |             |   |             |   |             |   |             |   |             |

**05 01012009**

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**120**

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**Doe, John**

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**1234567890**

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**Struck by lightning,**  
pt. badly burned and in shock

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THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.