The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.
# CHILDREN’S SERVICES HANDBOOK

## Table of Contents

1. **General Information** .......................................................... CH-17  
   1.1 Medical Transportation Program ........................................ CH-17  
   1.2 Rates Reduction ............................................................ CH-17  
   1.3 * Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission ........................................ CH-17  

2. **Medicaid Children’s Services Comprehensive Care Program (CCP)** ............... CH-18  
   2.1 CCP Overview .................................................................... CH-18  
   2.1.1 Client Eligibility ......................................................... CH-18  
   2.1.2 Enrollment ................................................................. CH-19  
   2.1.3 Services, Benefits, and Limitations .................................. CH-19  
   2.1.4 Prior Authorization and Documentation Requirements .......... CH-20  
      2.1.4.1 Diagnosis Coding .................................................. CH-20  
      2.1.4.2 Drug and Medical Device Approval ............................ CH-20  
      2.1.4.3 Physician Signature .............................................. CH-21  
   2.2 Certified Respiratory Care Practitioner Services (CCP) .................. CH-21  
      2.2.1 Services, Benefits, and Limitations ............................... CH-21  
      2.2.2 Prior Authorization and Documentation Requirements .......... CH-22  
   2.3 Clinician-Directed Care Coordination Services (CCP) .................. CH-23  
      2.3.1 * Services, Benefits, and Limitations ............................ CH-23  
      2.3.1.1 Non-Face-to-Face Services ..................................... CH-25  
         2.3.1.1.1 Non-Face-to-Face Medical Conferences .................. CH-25  
         2.3.1.1.2 Non-Face-to-Face Clinician Supervision of a Home Health Client CH-25  
         2.3.1.1.3 Non-Face-to-Face Clinician Supervision of a Hospice Client CH-25  
         2.3.1.1.4 Non-Face-to-Face Clinician Supervision of a Nursing Facility Client CH-25  
         2.3.1.1.5 Other Non-Face-to-Face Supervision ..................... CH-25  
         2.3.1.1.6 Non-Face-to-Face Prolonged Services .................... CH-25  
         2.3.1.1.7 Non-Face-to-Face Specialist or Subspecialist Telephone Consultation . CH-26  
         2.3.1.1.8 General Requirements for Non-Face-to-Face Clinician-Directed Care Coordination Services .................................. CH-26  
         2.3.1.1.9 Non-Face-to-Face Care Plan Oversight ..................... CH-26  
         2.3.1.1.10 Medical Team Conference .................................. CH-27  
      2.3.1.2 Face-to-Face Services ............................................. CH-27  
         2.3.1.2.1 * General Requirements for Face-to-Face Clinician-Directed Care Coordination Services .................................. CH-27  
      2.3.2 Prior Authorization and Documentation Requirements ................ CH-27  
      2.3.2.1 Documentation Requirements for the Medical Home Clinician for a Telephone Consult with a Specialist ................................ CH-29  
      2.3.2.2 Documentation Requirements for the Specialist or Subspecialist for a Telephone Consult with the Medical Home Clinician .............. CH-29  
   2.3.3 Claims Information ...................................................... CH-30  
   2.3.4 Reimbursement .......................................................... CH-30  

2.4 Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs) CH-30  
   2.4.1 Enrollment .............................................................. CH-30  
   2.4.2 Services, Benefits, and Limitations .................................. CH-30
2.4.3 Occupational Therapy ................................................................. CH-31
2.4.3.1 Services, Benefits, and Limitations .................................................. CH-31
2.4.3.2 Prior Authorization and Documentation Requirements ......................... CH-32
2.4.4 Physical Therapy ........................................................................... CH-33
2.4.4.1 Services, Benefits, and Limitations .................................................... CH-33
2.4.4.2 Prior Authorization and Documentation Requirements ......................... CH-34
2.4.5 Speech Therapy (ST) ..................................................................... CH-35
2.4.5.1 Services, Benefits, and Limitations ..................................................... CH-35
2.4.5.2 Prior Authorization and Documentation Requirements ......................... CH-35
2.4.6 Claims Information ....................................................................... CH-36
2.4.7 Reimbursement ............................................................................ CH-37

2.5 Durable Medical Equipment (DME) Supplier (CCP) ...................... CH-37
2.5.1 Enrollment ................................................................................... CH-37
2.5.1.1 Pharmacies (CCP) ........................................................................ CH-37
2.5.2 Services, Benefits, and Limitations .................................................. CH-37
2.5.2.1 Purchase Versus Equipment Rental ................................................... CH-39
2.5.3 Prior Authorization and Documentation Requirements ..................... CH-39
2.5.3.1 Equipment Accessories ................................................................. CH-40
2.5.3.2 Equipment Modifications ............................................................... CH-40
2.5.3.3 Equipment Adjustments ................................................................. CH-40
2.5.3.4 Equipment Repairs ....................................................................... CH-40
2.5.3.5 DME Certification and Receipt Form ................................................. CH-41
2.5.3.6 Documentation of Supply Delivery ................................................. CH-41
2.5.3.7 Specific CCP Policies ................................................................ CH-41
2.5.4 Blood Pressure Devices ................................................................. CH-42
2.5.4.1 Services, Benefits, and Limitations .................................................. CH-42
2.5.4.1.1 Manual and Automated Blood Pressure Devices .......................... CH-42
2.5.4.1.2 Hospital-Grade Blood Pressure Devices ........................................ CH-43
2.5.4.1.3 Blood Pressure Device Components, Replacements, and Repairs .... CH-43
2.5.4.2 Prior Authorization and Documentation Requirements ..................... CH-44
2.5.4.2.1 Manual and Automated Blood Pressure Devices .......................... CH-44
2.5.4.2.2 Hospital-Grade Blood Pressure Devices ........................................ CH-44
2.5.4.2.3 Blood Pressure Device Components, Replacements, and Repairs .... CH-45
2.5.5 Cardiorespiratory (Apnea) Monitor .................................................. CH-45
2.5.5.1 Services, Benefits, and Limitations .................................................. CH-45
2.5.5.2 Prior Authorization and Documentation Requirements ..................... CH-46
2.5.6 Pulse Oximeter ............................................................................ CH-46
2.5.6.1 Services, Benefits, and Limitations .................................................. CH-46
2.5.6.2 Prior Authorization and Documentation Requirements ..................... CH-46
2.5.7 Diabetic Equipment and Supplies .................................................... CH-47
2.5.7.1 Services, Benefits, and Limitations .................................................. CH-47
2.5.7.2 Prior Authorization and Documentation Requirements ..................... CH-48
2.5.7.2.1 Tubeless External Insulin Pump Rentals ........................................ CH-48
2.5.7.2.2 Purchase of Tubeless External Insulin Pump ................................ CH-49
2.5.8 Donor Human Milk ..................................................................... CH-49
2.5.8.1 Services, Benefits, and Limitations .................................................. CH-49
2.5.8.2 Prior Authorization and Documentation Requirements ..................... CH-50
2.5.9 Incontinence Supplies ................................................................. CH-50
2.5.9.1 Services, Benefits, and Limitations .................................................. CH-50
2.5.9.1.1 Skin Sealants, Protectants, Moisturizers, Ointments ..................... CH-51
2.5.9.1.2 Diapers, Briefs, and Liners .......................................................... CH-51
2.5.16 Vitamin and Mineral Products ...............................................................CH-75
  2.5.16.1 Services, Benefits, and Limitations ..............................................CH-75
  2.5.16.2 Prior Authorization and Documentation Requirements .................CH-79
2.5.17 Claims Information .................................................................CH-80
2.5.18 Reimbursement .................................................................CH-80

2.6 Early Childhood Intervention (ECI) Services ........................................CH-80
  2.6.1 Enrollment .................................................................CH-81
  2.6.2 Services, Benefits, Limitations, and Prior Authorization ...............CH-81
    2.6.2.1 Therapy .................................................................CH-81
      2.6.2.1.1 Occupational Therapy (OT) ..................................CH-81
      2.6.2.1.2 Physical Therapy (PT) ..................................CH-82
      2.6.2.1.3 Speech Therapy (ST) ..................................CH-83
    2.6.2.2 Specialized Skills Training (SST) ..................................CH-83
    2.6.2.3 Targeted Case Management (TCM) ..................................CH-84
  2.6.3 Documentation Requirements ..................................................CH-84
  2.6.4 Claims Filing and Reimbursement ...........................................CH-84
    2.6.4.1 Claims Information ..................................................CH-84
      2.6.4.1.1 Billing Units Based on 15 Minutes ...........................CH-85
      2.6.4.1.2 Managed Care Clients .....................................CH-85
    2.6.4.2 Reimbursement ..................................................CH-85

2.7 Medical Nutrition Counseling Services (CCP) ...................................CH-85
  2.7.1 Enrollment .................................................................CH-85
  2.7.2 Services, Benefits, and Limitations ...........................................CH-86
  2.7.3 Prior Authorization and Documentation Requirements .................CH-88
  2.7.4 Claims Information ...............................................................CH-89
  2.7.5 Reimbursement .................................................................CH-89

2.8 Orthotic and Prosthetic Services (CCP) ..............................................CH-89
  2.8.1 Enrollment .................................................................CH-89
  2.8.2 Orthotics Services .............................................................CH-89
    2.8.2.1 Services, Benefits, and Limitations ........................................CH-89
      2.8.2.1.1 Noncovered Orthotic Services .....................................CH-91
    2.8.2.2 Prior Authorization and Documentation Requirements ..............CH-91
      2.8.2.2.1 Spinal Orthoses ..................................................CH-92
      2.8.2.2.2 Lower-Limb Orthoses .........................................CH-93
      2.8.2.2.3 Foot Orthoses .....................................................CH-94
      2.8.2.2.4 Upper-Limb Orthoses ............................................CH-95
      2.8.2.2.5 Other Orthopedic Devices .....................................CH-95
      2.8.2.2.6 Related Services ..................................................CH-96
  2.8.3 Cranial Molding Orthosis ......................................................CH-96
    2.8.3.1 Services, Benefits, and Limitations ...................................CH-96
    2.8.3.2 Noncovered Services .....................................................CH-97
    2.8.3.3 Prior Authorization and Documentation Requirements ..............CH-97
  2.8.4 Thoracic-Hip-Knee-Ankle Orthoses (THKAO) (Vertical or Dynamic Standers, Standing Frames, Braces, and Parapodiums) ..................................................CH-97
    2.8.4.1 Services, Benefits, and Limitations ...................................CH-97
      2.8.4.1.1 Parapodium .........................................................CH-97
      2.8.4.1.2 Standing Frame or Brace .......................................CH-98
      2.8.4.1.3 Vertical or Dynamic Stander ..................................CH-98
    2.8.4.2 Prior Authorization and Documentation Requirements ..............CH-98
  2.8.5 Prosthetic Services ...............................................................CH-98
2.9 Personal Care Services (PCS) (CCP) ................. CH-105
  2.9.1 Enrollment .................................................. CH-105
  2.9.2 Services, Benefits, and Limitations ................... CH-106
    2.9.2.1 Place of Services ..................................... CH-108
    2.9.2.2 Client Eligibility ..................................... CH-108
    2.9.2.2.1 Accessing the PCS Benefit ......................... CH-109
    2.9.2.2.2 The Primary Practitioner's Role in the PCS Benefit CH-109
  2.9.3 Prior Authorization and Documentation Requirements .... CH-110
    2.9.3.1 PCS Provider Responsibilities ....................... CH-111
    2.9.3.2 Documentation of Services Provided and Retrospective Review CH-111
  2.9.4 Claims Information ........................................ CH-112
    2.9.4.1 Managed Care Clients ................................ CH-112
    2.9.4.2 PCS for STAR Health Clients ........................ CH-112
  2.9.5 Reimbursement ........................................... CH-112

2.10 Private Duty Nursing (PDN)(CCP) ................. CH-112
  2.10.1 Enrollment .................................................. CH-112
  2.10.2 Services, Benefits, and Limitations ................... CH-113
    2.10.2.1 PDN Provided During a Skill Nursing Visit for TPN Administration Education ........................................ CH-117
    2.10.2.2 Criteria ................................................ CH-117
      2.10.2.2.1 Client Eligibility Criteria ....................... CH-117
      2.10.2.2.2 Medical Necessity ............................... CH-118
    2.10.2.2.3 Place of Service (POS) ........................... CH-118
    2.10.2.2.4 Amount and Duration of PDN ........................ CH-118
  2.10.3 Prior Authorization and Documentation Requirements .... CH-118
    2.10.3.1 Retroactive Client Eligibility ....................... CH-120
    2.10.3.2 Start of Care (SOC) ................................ CH-121
    2.10.3.3 Prior Authorization of Initial Requests ............... CH-121
    2.10.3.4 Authorization for Revision of Current Services .......... CH-122
    2.10.3.5 Recertifications of Authorizations ................ CH-122
    2.10.3.6 Termination of Authorization ........................ CH-123
    2.10.3.7 Client and Provider Notification .................... CH-123
    2.10.3.8 Authorization Appeals ................................ CH-124
    2.10.3.9 CCP Prior Authorization Request Form ............... CH-124
    2.10.3.10 Home Health Plan of Care (POC) .................. CH-124
    2.10.3.11 Nursing Addendum to Plan of Care (CCP) Form ........ CH-125
      2.10.3.11.1 The client's 24-Hour Daily Schedule ........ CH-126
    2.10.3.12 Responsible Adult or Identified Contingency Plan Requirement CH-126
    2.10.3.13 Special Circumstances ............................ CH-126
    2.10.3.14 Documentation of Services Provided and Retrospective Review CH-127
2.10.4 Claims Information .......................................................... CH-127
2.10.5 Reimbursement .............................................................. CH-128

2.11 Therapy Services (CCP) ......................................................... CH-128
  2.11.1 Occupational Therapy (OT) ........................................... CH-129
    2.11.1.1 Enrollment ......................................................... CH-129
    2.11.1.2 Services, Benefits, and Limitations ......................... CH-129
    2.11.1.3 Prior Authorization and Documentation Requirements ........ CH-131
    2.11.1.4 Claims Information ............................................. CH-131
    2.11.1.5 Reimbursement ................................................. CH-132
  2.11.2 Physical Therapy (PT) .................................................. CH-132
    2.11.2.1 Enrollment ......................................................... CH-132
    2.11.2.2 Services, Benefits, and Limitations ......................... CH-132
    2.11.2.3 Prior Authorization and Documentation Requirements ........ CH-133
    2.11.2.4 Claims Information ............................................. CH-134
    2.11.2.5 Reimbursement ................................................. CH-134
  2.11.3 Speech Therapy (ST) ................................................... CH-135
    2.11.3.1 Enrollment ......................................................... CH-135
    2.11.3.2 Services, Benefits, and Limitations ......................... CH-135
    2.11.3.3 Prior Authorization and Documentation Requirements ........ CH-135
    2.11.3.4 Claims Information ............................................. CH-136
    2.11.3.5 Reimbursement ................................................. CH-137

2.12 Inpatient Psychiatric Hospital or Facility (Freestanding) (CCP) ........ CH-137

2.13 Inpatient Rehabilitation Facility (Freestanding) (CCP) .................. CH-137
  2.13.1 Enrollment .............................................................. CH-137
    2.13.1.1 Continuity of Hospital Eligibility Through Change of Ownership .... CH-137
    2.13.2 Services, Benefits, and Limitations .......................... CH-137
    2.13.2.1 Comprehensive Treatment ................................. CH-138
    2.13.3 Prior Authorization and Documentation Requirements ........ CH-138
    2.13.4 Claims Information ............................................. CH-139
    2.13.5 Reimbursement ................................................. CH-139
    2.13.5.1 Client Transfers ............................................... CH-140

3. School Health and Related Services (SHARS) ................................. CH-141

3.1 Overview ................................................................. CH-141
  3.1.1 Random Moment Time Study (RMTS) ................................ CH-141
  3.1.2 Eligibility Verification ............................................. CH-142

3.2 Enrollment ................................................................. CH-142
  3.2.1 SHARS Enrollment ................................................... CH-142
  3.2.2 Private School Enrollment .......................................... CH-142

3.3 Services, Benefits, Limitations, and Prior Authorization ................. CH-143
  3.3.1 Audiology ............................................................ CH-143
    3.3.1.1 Audiology Billing Table ...................................... CH-143
  3.3.2 Counseling Services ................................................ CH-144
    3.3.2.1 Counseling Services Billing Table ........................ CH-144
  3.3.3 Psychological Testing and Services ................................ CH-144
    3.3.3.1 Psychological Testing ........................................ CH-144
    3.3.3.1.1 Evaluation or Assessment Billing Table ................ CH-145
    3.3.3.2 Psychological Services ...................................... CH-145
    3.3.3.2.1 Psychological Services Billing Table .................. CH-146
  3.3.4 Nursing Services .................................................... CH-146
4.3.1 General Anesthesia .................................................. CH-218
4.3.2 Orthodontic Services ............................................. CH-218

4.4 Utilization Review ..................................................... CH-219

4.5 Claims Filing and Reimbursement ................................. CH-219
4.5.1 Reimbursement ...................................................... CH-219
4.5.2 Third Party Resources (TPR) ..................................... CH-219
4.5.3 Claim Submission After Loss of Eligibility ..................... CH-219
4.5.4 Claims Information .................................................. CH-220
4.5.5 Claim Appeals ....................................................... CH-220
4.5.6 Frequently Asked Questions About Dental Claims .......... CH-222

5. THSteps Medical .......................................................... CH-224

5.1 THSteps Medical and Dental Administrative Information .......... CH-224
5.1.1 Overview .............................................................. CH-224
5.1.2 Statutory Requirements ............................................ CH-225
5.1.3 Texas Vaccines for Children (TVFC) Program .................. CH-225
5.1.4 Vaccine Adverse Event Reporting System (VAERS) .......... CH-226
5.1.5 Referrals for Medicaid-Covered Services ....................... CH-226
5.1.6 THSteps Medical Checkup Facilities ............................. CH-227
5.1.7 THSteps Dental Services ............................................ CH-228

5.2 Enrollment .............................................................. CH-228
5.2.1 THSteps Medical Provider Enrollment .......................... CH-228
5.2.1.1 Requirements for Registered Nurses Who Provide Medical Checkups .... CH-229

5.3 Services, Benefits, Limitations, and Prior Authorization .......... CH-230
5.3.1 Eligibility for THSteps Services and Checkup Due Dates ....... CH-230
5.3.2 Prior Authorization .................................................. CH-231
5.3.3 Additional Consent Requirements ................................ CH-231
5.3.4 Verification of Medical Checkups ................................ CH-231
5.3.5 Medical Home ....................................................... CH-231
5.3.6 THSteps Medical Checkups ........................................ CH-231
5.3.7 Exception-to-Periodicity Checkups ............................... CH-234
5.3.8 Follow-up Medical Checkup ....................................... CH-235
5.3.9 Newborn Examination .............................................. CH-236
5.3.10 THSteps Medical Checkups Periodicity Schedule ............ CH-236
5.3.11 Mandated Components ............................................ CH-236
5.3.11.1 Comprehensive Health and Developmental History .......... CH-237
5.3.11.1.1 Nutritional Screening ....................................... CH-237
5.3.11.1.2 Developmental Surveillance or Screening .................. CH-237
5.3.11.1.3 Mental Health Screening .................................... CH-238
5.3.11.1.4 Tuberculosis (TB) Screening ............................... CH-239
5.3.11.2 Comprehensive Unclothed Physical Examination ............................... CH-239
  5.3.11.2.1 Oral Health Screening .......................................................... CH-239
  5.3.11.2.2 Sensory Screening ............................................................... CH-239
  5.3.11.2.3 Hearing Screening ............................................................... CH-239
  5.3.11.2.4 Vision Screening ................................................................. CH-240
5.3.11.3 Immunizations ................................................................. CH-240
  5.3.11.3.1 Vaccine Information Statement (VIS) ........................................ CH-242
5.3.11.4 Health Education and Anticipatory Guidance ....................... CH-243
5.3.11.5 Dental Referral ................................................................. CH-243
5.3.11.6 Laboratory Test ........................................................................ CH-243
  5.3.11.6.1 Laboratory Supplies .............................................................. CH-244
  5.3.11.6.2 Newborn Screening Supplies .................................................. CH-244
  5.3.11.6.3 Laboratory Submission .......................................................... CH-245
  5.3.11.6.4 Send Comments ....................................................................... CH-246
  5.3.11.6.5 Laboratory Reporting ............................................................. CH-246
  5.3.11.6.6 Required Laboratory Tests Related to Medical Checkups .......... CH-247
  5.3.11.6.7 Additional Required Laboratory Tests Related to Medical Checkups for Adolescents .................................................. CH-248
5.3.12 Non-mandated Components .................................................. CH-249
  5.3.12.1 Oral Evaluation and Fluoride Varnish (OEFV) in the Medical Home .... CH-249
5.4 Documentation Requirements ................................................... CH-250
  5.4.1 Separate Identifiable Acute Care Evaluation and Management Visit .......... CH-250
5.5 Claims Filing and Reimbursement ........................................ CH-251
  5.5.1 Claims Information ................................................................. CH-251
  5.5.2 Reimbursement ................................................................. CH-252
6. Claims Resources ........................................................................ CH-252
7. Contact TMHP ............................................................................ CH-253
  7.1 Automated Inquiry System (AIS) ......................................................... CH-253
  7.2 TMHP Website .................................................................................. CH-254
  7.3 Dental Information and Assistance ................................................ CH-254
    7.3.1 Dental Inquiry Line ....................................................................... CH-254
  7.4 THSteps Information and Assistance ............................................... CH-254
  7.5 Assistance with Program .................................................................. CH-254
8. Forms ......................................................................................... CH-254
  CH.1 CCP Prior Authorization Request Form Instructions (2 pages) ........... CH-255
  CH.2 CCP Prior Authorization Request Form ........................................ CH-257
  CH.3 CCP Prior Authorization Private Duty Nursing 6-Month Authorization ........ CH-258
  CH.4 CRCP Prior Authorization Request Form ........................................... CH-259
  CH.5 DME Certification and Receipt Form (3 Pages) ................................ CH-260
  CH.6 Donor Human Milk Request Form .................................................. CH-264
  CH.7 External Insulin Pump ....................................................................... CH-265
  CH.8 Home Health Plan of Care (POC) .................................................... CH-266
  CH.9 Nursing Addendum to Plan of Care (CCP) (7 Pages) ...................... CH-267
  CH.10 Pulse Oximeter Form ..................................................................... CH-274
  CH.11 Request for Initial Outpatient Therapy (Form TP-1) .......................... CH-275
  CH.12 Request for Extension of Outpatient Therapy (Form TP-2) (2 Pages) .... CH-276
  CH.13 THSteps Dental Mandatory Prior Authorization Request Form ........... CH-278
  CH.14 THSteps Dental Criteria for Dental Therapy Under General Anesthesia (2 Pages) .... CH-279
  CH.15 THSteps Referral Form Instructions ................................................. CH-281

CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.
19. Claim Form Examples .............................................................. CH-293
   CH.16 THSteps Referral Form ................................................. CH-282
   CH.17 CCP Prior Authorization Request for Non-Face-to-Face Clinician-Directed
       Care Coordination Services (2 Pages) ............................... CH-283
   CH.18 Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face
       Clinician-Directed Care Coordination Services–Comprehensive Care Program (CCP) CH-285
   CH.19 Wheelchair/ Scooter/ Stroller Seating Evaluation Form (CCP/Home
       Health Services) (7 Pages) .............................................. CH-286

9. Claim Form Examples .............................................................. CH-293
   CH.20 Comprehensive Outpatient Rehabilitation Facility (CORF) (CCP Only) ........ CH-294
   CH.21 Diagnosis and Treatment (Referral from THSteps Checkup) .................... CH-295
   CH.22 Durable Medical Equipment (CCP Only) .................................. CH-296
   CH.23 Early Childhood Intervention Specialized Skills Training (SST) ................. CH-297
   CH.24 Early Childhood Intervention Targeted Case Management with Face-to-Face
       Interaction ................................................................. CH-298
   CH.25 Early Childhood Therapy .............................................. CH-299
   CH.26 Inpatient Rehabilitation Facility (Freestanding) (CCP Only) ................... CH-300
   CH.27 Medical Nutrition Counseling (CCP Only) ................................ CH-301
   CH.28 Occupational Therapists (CCP Only) .................................... CH-302
   CH.29 Orthotic and Prosthetic Services (CCP Only) ................................ CH-303
   CH.30 Physical Therapists (CCP Only) ......................................... CH-304
   CH.31 Private Duty Nurses (CCP Only) ........................................ CH-305
   CH.32 School Health and Related Services (SHARS) ................................ CH-306
   CH.33 Speech-Language Pathologists (CCP Only) .................................. CH-307
   CH.34 THSteps New Patient, Immunization Without Counseling no Referral and by a NP CH-308
   CH.35 THSteps Established Patient Exception to Periodicity and Referral,
       Immunizations with Counseling, and by a Physician .................... CH-309
   CH.36 THSteps Established Patient and Referral, Tuberculin Skin Test (TST), and
       Physical Examination by a Physician ................................ CH-310

Appendix A: THSteps Forms ....................................................... CH-311
   A.1 Claim Forms ................................................................. CH-312
   A.2 THSteps Medical Checkup Forms ........................................ CH-312
   A.3 Laboratory Forms .......................................................... CH-313
   A.4 Guidelines for Tuberculosis Skin Testing .................................. CH-313
   A.5 Tuberculosis Screening and Guidelines .................................... CH-313
   CH.37 How to Determine TB Risk ............................................. CH-315
   A.6 Texas Vaccines For Children (TVFC) ...................................... CH-316
   CH.38 TVFC Patient Eligibility Screening Record .............................. CH-316
   CH.39 TVFC Patient Eligibility Screening Record (Spanish) ................. CH-317
   CH.40 TVFC Provider Enrollment (3 Pages) .................................. CH-318
   CH.41 TVFC Questions and Answers (3 Pages) ................................ CH-321

Appendix B: Immunizations ......................................................... CH-325
   B.1 Immunizations Overview .................................................. CH-326
       B.1.1 Vaccine Adverse Event Reporting System (VAERS) ................... CH-326
       B.1.2 TVFC Versus Non-TVFC Vaccines/Toxoids .......................... CH-326
       B.1.3 Exemption from Immunization for School and Child-Care Facilities CH-326
   B.2 Recommended Childhood Immunization Schedule ......................... CH-327
       B.2.1 Recommended Childhood and Adolescent Immunization Schedule, 2013 CH-328
   B.3 General Recommendations ................................................ CH-332
       B.3.1 How to Obtain Vaccines at No Cost to the Provider ................. CH-332
Appendix F: THSteps Quick Reference Guide ........................................... CH-355
  F.1 Texas Health Steps Quick Reference Guide ................................. CH-356
Appendix G: THSteps Dental Guidelines ................................. CH-359
  G.1 American Academy of Pediatric Dentistry Periodicity Guidelines (9 Pages) .... CH-360
  G.2 American Dental Association Guidelines for Prescribing Dental Radiographs
     (3 Pages) ................................................................................ CH-369
1. GENERAL INFORMATION

The information in this handbook is intended for dentists, school districts, physicians, physician assistants (PAs), rural health clinics (RHCs), federally qualified health centers (FQHCs), advanced practice registered nurses (APRNs), home health agencies (HHAs), durable medical equipment (DME) suppliers, hospitals, and clinics. The handbook provides information about Texas Medicaid’s benefits, policies, and procedures applicable to these providers.

Important: All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

All providers are required to report suspected child abuse or neglect as outlined in Subsection 1.6, “Provider Responsibilities” in Section 1, “Provider Enrollment and Responsibilities” (Vol 1, General Information).

1.1 Medical Transportation Program

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

Refer to: The Medical Transportation Program Handbook (Vol. 2, Provider Handbooks) for more information.

1.2 Rates Reduction

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 Texas Medicaid & Healthcare Partnership (TMHP) website at www.tmhp.com/pages/topics/rates.aspx.

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 time frame 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.

These reimbursement guidelines do not apply in the following circumstances:

- Services are rendered at a federally qualified health center (FQHC) or rural health clinic (RHC).
• Services are for a THSteps medical checkup.
• Professional services are rendered in the inpatient hospital setting.
• The hospital and the physician office or other entity are both owned by a third party, such as a health system.
• The hospital is not the sole or 100-percent owner of the entity.

These reimbursement guidelines do not apply for FQHC, RHC, THSteps, and professional services that are rendered in the inpatient hospital setting.

Refer to: Subsection 3.6.3.8, “Payment Window Reimbursement Guidelines” of the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about the payment window reimbursement guidelines.

2. MEDICAID CHILDREN’S SERVICES COMPREHENSIVE CARE PROGRAM (CCP)

2.1 CCP Overview

CCP is an expansion of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) service as mandated by the Omnibus Budget Reconciliation Act (OBRA) of 1989, which requires all states to provide all medically necessary treatment for correction of physical or mental problems to Texas Health Steps (THSteps)-eligible clients when federal financial participation (FFP) is available, even if the services are not covered under the state’s Medicaid plan.

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

• Subsection 2.3, “Clinician-Directed Care Coordination Services (CCP)” in this handbook.
• Subsection 2.4, “Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)” in this handbook.
• Subsection 2.5, “Durable Medical Equipment (DME) Supplier (CCP)” in this handbook.
• Subsection 2.6, “Early Childhood Intervention (ECI) Services” in this handbook.
• Subsection 2.7, “Medical Nutrition Counseling Services (CCP)” in this handbook.
• Subsection 2.8, “Orthotic and Prosthetic Services (CCP)” in this handbook.
• Subsection 2.9, “Personal Care Services (PCS) (CCP)” in this handbook.
• Subsection 2.10, “Private Duty Nursing (PDN)(CCP)” in this handbook.
• Subsection 2.11, “Therapy Services (CCP)” in this handbook.
• Subsection 2.13, “Inpatient Rehabilitation Facility (Freestanding) (CCP)” in this handbook.

2.1.1 Client Eligibility

The client must be birth through 20 years of age and eligible for THSteps on the date of service. If the client’s Your Texas Benefits card states “Emergency Care,” “PE,” or “QMB,” the client is not eligible for CCP benefits.

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

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

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

Home and community support services agencies (HCSSAs) that want to provide CCP private-duty nursing (PDN), home telemonitoring, occupational therapist, physical therapist, or speech therapist services under the licensed-only home health (LHH) category must first enroll with TMHP. To enroll with TMHP in the LHH category, an HCSSA must:

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

2.1.3 Services, Benefits, and Limitations

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

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

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

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

2.1.4 Prior Authorization and Documentation Requirements

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

Prior authorization of CCP services may be requested in writing by completing the appropriate request form, attaching any necessary supportive documentation, and mailing or faxing it to the TMHP-CCP department. Prior authorization may also be requested through the TMHP website. (Providers can refer to subsection 5.5.1, “Prior Authorization Requests Through the TMHP Website” in Section 5, “Prior Authorization” (Vol. 1, General Information) for additional information to include mandatory documentation and retention requirements). All requested information on the form must be completed, or the request is returned to the provider. Incomplete forms are not accepted. If prior authorization is granted, the potential service provider (such as the DME supplier, pharmacy, registered nurse (RN), or physical therapist) receives a letter that includes the PAN, the procedures prior authorized, and the length of the authorization. Providers are notified in writing when additional information is needed to process the request for services.

Providers must submit a CCP Prior Authorization Request Form and documentation to support medical necessity to the CCP department before providing services. Providers must submit the CCP Prior Authorization Request Form when requesting a medically necessary service if the service is not addressed in the Texas Medicaid Provider Procedures Manual and the client is 20 years of age or younger.

Important: Documentation to support medical necessity of the service, equipment, or supply (such as a prescription, letter, or medical records) must be current, signed, and dated by a physician (M.D. or D.O.) before services are performed. Providers must keep the information on file.

Refer to: CCP provider-specific sections for prior authorization requirements of specific services, including the appropriate prior authorization request forms.

2.1.4.1 Diagnosis Coding

All providers must obtain the client’s medical diagnosis from the physician. This information must be reflected on each claim submitted to TMHP using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding.

2.1.4.2 Drug and Medical Device Approval

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

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

HHSC reviews the information. Requests for consideration must not be sent to TMHP.
2.1.4.3 **Physician Signature**

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

Stamped signatures and dates are not accepted on CCP Authorization Request Forms or prescriptions for CCP prior authorized services, supplies, or equipment. Verbal orders must be cosigned and dated by a physician (M.D. or D.O.) within two weeks, per provider policy. Signatures of chiropractors or doctors of philosophy (PhDs) are not accepted on CCP Authorization Request Forms or prescriptions for CCP prior authorized services.

Certified nurse midwife (CNM), clinical nurse specialist (CNS), nurse practitioner (NP), and PA providers may sign on behalf of the physician for private duty nursing, physical, occupational and speech therapy services when the physician delegates this authority.

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

### 2.2 Certified Respiratory Care Practitioner Services (CCP)

2.2.1 **Services, Benefits, and Limitations**

In-home certified respiratory care practitioner (CRCP) services are a benefit of the CCP for non-ventilator-dependent clients who are 20 years of age and younger.

**Refer to:** Subsection 2.2, “Certified Respiratory Care Practitioner Services (CCP)” in the *Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks)* for information about respiratory care practitioner services for ventilator-dependent clients.

In-home respiratory services are a benefit when provided to clients who have a chronic, underlying respiratory illness or a newly diagnosed long-term respiratory condition that currently results in a suboptimal respiratory status. These services are designed to maximize the client’s or caregiver’s ability to manage the client’s disease when the physician deems the client or caregiver will benefit from the expertise of a respiratory care practitioner for the provision of respiratory care or education.

A CRCP must hold a certificate or temporary permit in compliance with the Texas Occupations Code, Chapter 604, Subchapter A. CRCPs must be enrolled with Texas Medicaid as an independent practitioner or be employed by a physician, physician group, or home health agency.

The CRCP’s services allow for the performance of pulmonary care, when required, and the education of the client or caregiver in the following:

- Disease management
- Prevention of infections and complications
- Proper use of medications and respiratory equipment that the client is using

Respiratory therapy care services that do not require the specialty of a CRCP are not a benefit.

In-home respiratory services must be billed using procedure codes 98960, 99503, and S9441. Procedure codes 98960, 99503, and S9441 are limited to twice per lifetime. Services that exceed the twice-per-lifetime limitation must meet additional criteria for prior authorization.

Only one procedure code (98960, 99503, 99504, or S9441) may be reimbursed per day, to any provider.
2.2.2 Prior Authorization and Documentation Requirements

Prior authorization is required for in-home respiratory services (procedure codes 98960, 99503, and S9441). Prior authorization requests must be submitted on the CRCP Prior Authorization Request Form.

Refer to: Form CH.4, “CRCP Prior Authorization Request Form”

Providers must submit the following documentation to the CCP Prior Authorization Unit:

- A physician’s order
- Client’s primary diagnosis with details of current suboptimal respiratory status and history of more than one emergency room or acute care clinic visit within the last three months
- The services that the CRCP will provide
- Reason this service/education needs to be provided in the home setting and not in the office or facility setting. Reasons may include, but are not limited to, the following:
  - Testing of home equipment
  - Evaluation of the patient/caregiver’s technique with home respiratory care equipment
  - Evaluation of caregiver’s ability to assess the client’s respiratory status and intervene appropriately if necessary
  - Assessment of the home environment
- The goals of the services to be provided in the home and the estimated length of time to attain these goals

Procedure code S9441 must be performed by a CRCP who has been certified by the National Asthma Educator Certification Board (NAECB) as a certified asthma educator. Certification documentation must be provided with the CRCP Prior Authorization Request Form in order to be considered for prior authorization. Asthma conditions may include, but are not limited to, the following:

- Extrinsic asthma
- Intrinsic asthma
- Chronic obstructive asthma
- Exercise-induced asthma

For procedure codes 98960 and 99503, covered respiratory conditions may include, but are not limited to, the following:

- Cystic fibrosis
- Obstructive sleep apnea (use of continuous positive airway pressure [CPAP] or bi-level positive airway pressure [BiPAP])
- Chronic respiratory insufficiency

Prior authorization requests for conditions or quantities beyond two per lifetime will be considered on a case-by-case basis upon review by the TMHP Medical Director. Providers must submit the following additional information when requesting prior authorization beyond the two-per-lifetime limit:

- Documentation that the objectives of prior visits were not yet achieved
- Reason the additional services need to be provided in the home setting
- The goals of these services and the estimated length of time to attain these goals
- The frequency and number of home visits requested by the CRCP
To avoid unnecessary denials, the provider must submit correct and complete information, including documentation for medical necessity of the service requested. The provider ordering the service and the provider performing the service must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for the service.

A completed CRCP Prior Authorization Request Form requesting these services must be signed and dated by the treating physician familiar with the client before requesting prior authorization. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures/dates will not be accepted. A copy of the completed, signed, and dated CRCP Prior Authorization Request Form must be maintained by the provider in the client’s medical record. The completed CRCP Prior Authorization Request Form with the original dated signature must be maintained by the prescribing physician in the client’s medical record.

To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated CRCP Prior Authorization Request Form in the client’s medical record at the provider’s place of business.

To complete the prior authorization process by paper, the provider must fax or mail the completed CRCP Prior Authorization Request Form to the CCP Prior Authorization Unit and retain a copy of the signed and dated CRCP Prior Authorization Request Form in the client’s medical record at the provider’s place of business.

2.3 Clinician-Directed Care Coordination Services (CCP)

2.3.1 * Services, Benefits, and Limitations

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

To provide a medical home for the client, the primary care clinician directs care coordination together with the client and family. Care coordination consists of managing services and resources for clients with special health needs and their families to maximize the clients’ potential and provide them with optimal health care.

Clinician-directed care coordination services (face-to-face and non-face-to-face) must include the following components:

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

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

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

- Assistance for the client or family in communicating clinical issues when a client is referred for a consultation or additional care, such as evaluation, interpretation, implementation, and management of the consultant recommendations for the client or family in partnership and collaboration with other providers, the client, or family.
Clinician-directed care coordination services must also include the supervision of the development and revision of the client’s emergency medical plan in partnership with the client, the family, and other providers for use by emergency medical services (EMS) personnel, utility service companies, schools, other community agencies, and caregivers.

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

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

- Prolonged services (procedure codes 99358 and 99359).
- Medical team conference (procedure code 99367).
- Care plan oversight and supervision, including telephone consultations with a specialist or subspecialist (procedure codes 99339, 99340, 99374, 99375, 99377, 99378, 99379, and 99380).
- Specialist or subspecialist telephone consultations (procedure code 99499 with modifier U9).

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

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

- Review of charts, reports, treatment plans, and lab or study results, except for the initial interpretation or review of lab or study results ordered during, or associated with, a face-to-face encounter.
- Telephone calls with other Medicaid-enrolled health-care professionals (not employed in the same practice) involved in the care of the client.
- Telephone or face-to-face discussions with a pharmacist about pharmacological therapies (not just ordering a prescription).
- Medical decision-making.
- Activities to coordinate services, if the coordination activities require the skill of a clinician.
- Documenting the services provided, which includes writing a note in the client’s chart describing the services provided, decision-making performed, and the amount of time spent performing the countable services, including the start and stop times and time spent by the physician working on the care plan after the nurse has conveyed pertinent information from agencies and facilities to the physician.

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

- Time that the staff spends getting or filing charts, calling home health agencies or clients, and similar administrative actions.
- Clinician telephone calls to client or family, except when necessary to discuss changes in client’s care plan.
- Clinician time spent telephoning prescriptions to a pharmacist (does not require clinician work and does not require a clinician to perform).
- Clinician time getting or filing the chart, dialing the telephone, or time on hold (does not require clinician work and does not meaningfully contribute to the treatment of the illness or injury).
- Travel time.
- Time spent preparing claims and for claims processing.
• Initial interpretation or review of lab or study results that were ordered during, or associated with, a face-to-face encounter.
• Services included as part of other E/M services.
• Consultations with health professionals not involved in the client’s case.

2.3.1.1 Non-Face-to-Face Services

2.3.1.1.1 Non-Face-to-Face Medical Conferences
Procedure code 99367 must be used when billing for medical team conferences.

2.3.1.1.2 Non-Face-to-Face Clinician Supervision of a Home Health Client
Procedure code 99374 or 99375 must be used when billing for services requiring interaction with a home health agency.

2.3.1.1.3 Non-Face-to-Face Clinician Supervision of a Hospice Client
Procedure code 99377 or 99378 must be used when billing for services requiring interaction with a hospice.

2.3.1.1.4 Non-Face-to-Face Clinician Supervision of a Nursing Facility Client
Procedure code 99379 or 99380 must be used when billing for services requiring interaction with a nursing facility.

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

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

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

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

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

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

| Procedure Codes | 99201 | 99202 | 99203 | 99204 | 99205 | 99211 | 99212 | 99213 | 99214 | 99215 |
Procedure code 99359 is used to report an additional 15 to 30 minutes of prolonged non-face-to-face services beyond the first hour. Prolonged services of less than 15 minutes beyond the first hour are considered part of the first hour.

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

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

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99339</td>
</tr>
</tbody>
</table>

Because the specialist or sub-specialists cannot be reimbursed without the medical home clinician’s current prior authorization information, the clinician providing the medical home should provide their information to the specialist or subspecialist.

The specialist or subspecialist will not be separately reimbursed for the telephone consultation if he or she is the medical home clinician because care plan oversight by the medical home provider includes telephone consultations. The referring provider identifier and prior authorization number must be submitted on the claim.

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

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

2.3.1.1.9 Non-Face-to-Face Care Plan Oversight

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

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

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

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

Procedure code 99379 is denied when billed on the same date of service by the same provider as procedure code 99380.
Care plan oversight services may be reimbursed for the clinician time involved in this coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to or performed by others do not count towards care coordination reimbursement.

Only one clinician-directed care plan oversight service (procedure codes 99339, 99340, 99374, 99375, 99377, 99378, 99379 or 99380) is reimbursed every six months.

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

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

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

2.3.1.10 Medical Team Conference

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

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

The medical team conference time must be documented in the client’s record.

2.3.1.2 Face-to-Face Services

2.3.1.2.1 General Requirements for Face-to-Face Clinician-Directed Care Coordination Services

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

- When counseling or care coordination requires more than 50 percent of the client or family encounter (face-to-face time in the office or other outpatient setting, or floor/unit time in the hospital), then time may be considered the key or controlling factor to qualifying for a particular level of E/M service.
- Counseling is a discussion with the client or family concerning diagnostic studies or results, prognosis, risks and benefits, management options, importance of adhering to the treatment regimen, and client and family education.

Modifiers must be used as appropriate for billing.

Any face-to-face inpatient or outpatient E/M procedure code that is a benefit of Texas Medicaid may be billed on the same day as the following non-face-to-face clinician-directed care coordination procedure codes when the procedure requires significant, separately-identifiable E/M services by the same physician on the same day.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99339</td>
</tr>
</tbody>
</table>

2.3.2 Prior Authorization and Documentation Requirements

Non-face-to-face clinician-directed care coordination services provided by the medical home require prior authorization. Providers must submit a request for prior authorization within seven business days of the date of service. Prior authorization is limited to a maximum of six months. Prior authorization is required to recertify the client for additional six-month periods and requires submission of a new request with documentation supporting medical necessity for ongoing services.
Prior authorization for initial non-face-to-face clinician-directed care coordination requires documentation of at least one covered face-to-face inpatient or outpatient E/M visit by the medical home clinician directing the care coordination during the six months preceding the provision of the first non-face-to-face care coordination service.

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

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

Texas Medicaid & Healthcare Partnership
Comprehensive Care Program
PO Box 200735
Austin, TX 78720-0735
Fax: (512) 514-4212

For prior authorization to be considered, clients must require complex and multidisciplinary care modalities involving regular clinician development or revision of care plans, review of subsequent reports of client status, and review of related laboratory and other studies:

- **Medically complex.** The health care needed by a Medicaid client achieves the designation of medically complex when the approved POC necessitates a clinical professional practicing within the scope of his or her license and in the context of a medical home to coordinate ongoing treatment to ensure its safe and effective delivery. The diagnosis must be covered under Texas Medicaid and be characterized by one of the following:

  - Significant and interrelated disease processes that involve more than one organ system (including behavioral health diagnoses) and require the services of two or more licensed clinical professionals, specialists, or subspecialists.

  - Significant physical or functional limitations that require the services of two or more therapeutic or ancillary disciplines, including, but not limited to, nursing, nutrition, OT, PT, ST, orthotics, and prosthetics.

  - Significant physical, developmental, or behavioral impairment that requires the integration of two or more medical or community-based providers, including, but not limited to, educational, social, and developmental professionals, that impact the care of the client.

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

Prior authorization is effective for care coordination services provided over a period of six months. Medical home clinicians must submit a revised care plan for subsequent periods of prior authorization. Documentation of the following components must be submitted with the prior authorization form to obtain an initial authorization or renewal:

- A current medical summary, encompassing all disciplines and all aspects of the client’s care, and containing key information about the client’s health, including conditions, complexity, medications, allergies, past surgical procedures, and so on.

- A current list of the main concerns, issues, and problems as well as key strengths and assets and the related current clinical information including a list of all diagnoses with ICD-9-CM diagnosis codes.
• Planned action steps and interventions to address the concerns and to sustain and build strengths, with the expected outcomes.

• Disciplines involved with the client’s care and how the multiple disciplines will work or are working together to meet the client’s need. Providers must explain how the multidisciplinary approach will or do benefit the client’s needs.

• Short-term and long-term goals with timeframes.

The supporting documentation can be any of the following:

• A formal written care plan

• Progress note detailing the care coordination planning

• A letter of medical necessity detailing the care plan oversight and care coordination

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

• Problem list

• Interventions

• Short-term and long-term goals

• Responsible parties

Client medical records are subject to retrospective review.

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

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

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

• Start and stop times showing that the consultation was at least 15 minutes

• The reason for the call

• The specialist’s or subspecialist’s medical opinion

• The recommended treatment or laboratory services

• The name of the specialist or subspecialist

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

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

• The client’s name, date of birth, and Medicaid identification number

• Start and stop times indicating the consultation lasted at least 15 minutes

• The reason for the call
• The specialist’s or subspecialist’s medical opinion
• The recommended treatment or laboratory services
• The name and telephone number of the clinician providing the medical home
• Provider information for the specialist’s or subspecialist’s and the clinician providing the medical home

2.3.3 Claims Information
Claims for clinician-care coordination services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper 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.
Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, Claims Filing (Vol. 1, General Information) for instructions on completing paper claims.

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

2.4 Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)

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

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

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

2.4.2 Services, Benefits, and Limitations
OT, PT, and ST services are a benefit for clients who are 20 years of age or younger and who are CCP eligible when:
• Therapy is prescribed by a licensed physician.
• Documentation of medical necessity supports a condition that requires ongoing therapy or rehabilitation in the usual course, treatment, and management of the client’s condition.
• Therapy services are provided by a licensed therapist in an outpatient rehabilitation facility.

Therapy may be performed by a licensed occupational therapist, physical therapist, speech therapist, or one of the following under the supervision of a licensed therapist: licensed therapy assistant or licensed speech-language pathology intern.

Services performed by an occupational therapist aide, occupational therapist orderly, occupational therapist student, occupational therapist technician, physical therapist aide, physical therapist orderly, physical therapist student, physical therapist technician, SLP aide, SLP orderly, SLP student, or SLP technician are not a benefit of Texas Medicaid.

Therapy services performed by an unlicensed provider are subject to retrospective review and recoupment.
CORT and ORF services provided at schools, homes, daycare facilities, or any other non-Medicare-approved ORF or CORF facility is not a covered CCP benefit.

**Services That Are Not a Benefit**

The following services are not a benefit of CCP:

- Procedure code 97010 (application of a modality to one or more areas; hot or cold packs).
- Services that are not medically necessary. Examples include, but are not limited to:
  - Massage therapy that is the sole therapy or is not part of a therapeutic POC to address an acute condition.
  - Hippotherapy.
  - Separate reimbursement for VitalStim® therapy for dysphagia.
  - Treatment solely for the instruction of other agency or professional personnel in the client’s PT, OT, or ST program.
  - Training in nonessential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling).
  - Emotional support, adjustment to extended hospitalization or disability, and behavioral readjustment.
- Therapy prescribed primarily as an adjunct to psychotherapy.

**2.4.3 Occupational Therapy**

**2.4.3.1 Services, Benefits, and Limitations**

A procedural modifier is required when submitting claims for occupational therapist services. Providers must use modifier GO for occupational therapist services. Procedural modifiers are not required for evaluations and re-evaluations.

Evaluations (procedure code 97003) are limited to once every 180 calendar days, any provider. Re-evaluations (procedure code 97004) are limited once per 30 calendar days, any provider.

An evaluation or re-evaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

If a therapy evaluation or re-evaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied.

OT evaluation (procedure code 97003) or re-evaluation (procedure code 97004) will be denied as part of the following OT procedure codes billed with Modifier GO.

The following procedure codes are billed in 15-minute increments:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012 97014 97016 97018 97022 97024 97026 97028 97032 97033</td>
</tr>
<tr>
<td>97034 97035 97036 97039 97110 97112 97113 97116 97124 97139</td>
</tr>
<tr>
<td>97140 97150 97530 97535 97537 97542 97750 97760 97761 97762</td>
</tr>
<tr>
<td>97799</td>
</tr>
</tbody>
</table>

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to two hours (eight units) per day of individual, group, or a combination of individual and group therapy, per therapy type (two hours of OT and two hours of PT). Each 15 minutes equals one unit.
All 15-minute increment procedure codes are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units must be rounded up or down to the nearest quarter hour.

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

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not evenly divisible by 15, minutes greater than 7 are converted to 1 unit and 7 or fewer minutes are converted to 0 unit.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to 1 unit. Consequently, 68 total billable minutes = 5 units of service. The following table indicates the time intervals for 0 through 8 units:

<table>
<thead>
<tr>
<th>Units</th>
<th>Number of Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 units</td>
<td>0 minutes through 7 minutes</td>
</tr>
<tr>
<td>1 units</td>
<td>8 minutes through 22 minutes</td>
</tr>
<tr>
<td>2 units</td>
<td>23 minutes through 37 minutes</td>
</tr>
<tr>
<td>3 units</td>
<td>38 minutes through 52 minutes</td>
</tr>
<tr>
<td>4 units</td>
<td>53 minutes through 67 minutes</td>
</tr>
<tr>
<td>5 units</td>
<td>68 minutes through 82 minutes</td>
</tr>
<tr>
<td>6 units</td>
<td>83 minutes through 97 minutes</td>
</tr>
<tr>
<td>7 units</td>
<td>98 minutes through 112 minutes</td>
</tr>
<tr>
<td>8 units</td>
<td>113 minutes through 127 minutes</td>
</tr>
</tbody>
</table>

Electrical stimulation therapy (procedure code 97032) may be considered with documentation of medical necessity.

2.4.3.2 Prior Authorization and Documentation Requirements

Prior authorization is required for OT except evaluations and re-evaluations.

The following documentation must be submitted to TMHP prior to the start of care for the current episode of therapy for consideration for prior authorization:

- A current written order by a physician based on medical necessity.
- A prescription is considered current when it is signed and dated, on or no later than, 60 days before the start of therapy.
- A "Request for Initial Outpatient Therapy (Form TP-1)" or "Request for Extension of Outpatient Therapy (Form TP-2) (2 Pages)" must be submitted to TMHP prior to the start of care for the current episode of therapy.
- The most recent evaluation and treatment plan. To establish medical necessity, the written treatment plan must include the following:
  - The age of the client at the time of evaluation.
  - Diagnosis.
  - Description of specific therapy being prescribed.
  - Specific treatment goals related to the client’s individual needs. Therapy goals may include improving function, maintenance of function, or slowing of the deterioration of function.
• For an initial request, anticipated measurable progress toward goals, the prognosis, and the client’s
gross motor skills in years or months.

• For a new request for additional therapy, documentation of all progress made from the beginning
of the previous treatment period.

• Duration and frequency of therapy.

• Requested date of service.

The number of sessions per week must be supported by documentation supporting the medical necessity
for the frequency requested.

When requesting prior authorization for group OT, the provider must submit documentation
supporting the group process as being medically necessary and beneficial to the client. When group
therapy is authorized, weekly therapy limits will not be exceeded.

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on
behalf of the client’s physician when the physician delegates this authority.

A request for occupational therapist services may be prior authorized for no longer than 180 days
duration. A new request must be submitted if therapy is required for a longer duration. A physician’s
prescription is required every 180 days.

The GO modifier is required on all prior authorization requests for OT.

If a provider discontinues therapy with a client and a new provider begins therapy during an existing
authorization period, submission of a new plan of care and documentation of the last therapy visit with
the previous provider is required along with a letter from the client, or responsible adult, stating the date
therapy ended with the previous provider.

2.4.4 Physical Therapy

2.4.4.1 Services, Benefits, and Limitations

A procedural modifier is required when submitting claims for physical therapist services. Providers
must use modifier GP for physical therapist services. Procedural modifiers are not required for evalua-
tions and re-evaluations.

Evaluations (procedure code 97001) are limited to once every 180 calendar days, any provider. Re-evalu-
atations (procedure code 97002) are limited to once per 30 calendar days, any provider.

An evaluation or re-evaluation performed on the same day as therapy from a different therapy type must
be performed at distinctly separate times to be considered for reimbursement.

If a therapy evaluation or re-evaluation procedure code and like therapy procedure codes are billed for
the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied.

PT evaluation (procedure code 97001) or re-evaluation (procedure code 97002) will be denied as part of
the following PT procedure codes billed with Modifier GP.

The following procedure codes are billed in 15-minute increments:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012 97014 97016 97018 97022 97024 97026 97028 97032 97033</td>
</tr>
<tr>
<td>97034 97035 97036 97039 97110 97112 97113 97116 97124 97139</td>
</tr>
<tr>
<td>97140 97150 97530 97535 97537 97542 97750 97760 97761 97762</td>
</tr>
<tr>
<td>97799 S8990</td>
</tr>
</tbody>
</table>
Procedure codes that may be submitted in multiple quantities (i.e., 15 minutes each) are limited to two hours (eight units) per day of individual, group, or a combination of individual and group therapy, per therapy type (two hours of OT, two hours of PT). Each 15 minutes equals one unit.

All 15-minute increment procedure codes are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units must be rounded up or down to the nearest quarter hour.

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

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not evenly divisible by 15, minutes greater than 7 are converted to 1 unit, and 7 or fewer minutes are converted to 0 unit.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to 1 unit. Consequently, 68 total billable minutes = 5 units of service.

Refer to: Section 2.4.3, "Occupational Therapy" in this handbook for the 15-minute conversion table.

Electrical stimulation therapy (procedure code 97032) may be considered with documentation of medical necessity.

2.4.4.2 Prior Authorization and Documentation Requirements

Prior authorization is required for PT except evaluations and re-evaluations.

The following documentation must be submitted to TMHP prior to the start of care for the current episode of therapy for consideration for prior authorization:

- A current written order by a physician based on medical necessity.
- A prescription is considered current when it is signed and dated on, or no later than, 60 days before the start of therapy.
- A "Request for Initial Outpatient Therapy (Form TP-1)” or “Request for Extension of Outpatient Therapy (Form TP-2) (2 Pages)” must be submitted to TMHP prior to the start of care for the current episode of therapy.
- The most recent evaluation and treatment plan. To establish medical necessity, the written treatment plan must include the following:
  - The age of the client at the time of evaluation.
  - Diagnosis.
  - Description of specific therapy being prescribed.
  - Specific treatment goals related to the client’s individual needs. Therapy goals may include improving function, maintenance of function, or slowing of the deterioration of function.
  - For an initial request, anticipated measurable progress toward goals, the prognosis, and the client’s gross motor skills in years or months.
  - For a new request for additional therapy, documentation of all progress made from the beginning of the previous treatment period.
  - Duration and frequency of therapy.
  - Requested date of service.
The number of sessions per week must be supported by documentation supporting the medical necessity for the frequency requested.

When requesting prior authorization for group PT, the provider must submit documentation supporting the group process as being medically necessary and beneficial to the client. When group therapy is authorized, weekly therapy limits will not be exceeded.

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on behalf of the client’s physician when the physician delegates this authority.

A request for physical therapist services may be prior authorized for no longer than 180 days duration. A new request must be submitted if therapy is required for a longer duration. A physician’s prescription is required every 180 days.

The GP modifier is required on all prior authorization requests for PT.

If a provider discontinues therapy with a client and a new provider begins therapy during an existing authorization period, submission of a new plan of care and documentation of the last therapy visit with the previous provider is required along with a letter from the client, or responsible adult, stating the date therapy ended with the previous provider.

### 2.4.5 Speech Therapy (ST)

#### 2.4.5.1 Services, Benefits, and Limitations

A procedural modifier is required when submitting claims for ST services. Providers must use modifier GN for ST services. Procedural modifiers are not required for evaluations and re-evaluations.

ST evaluations (procedure code 92506) are limited to once every 180 calendar days, any provider. ST re-evaluations (procedure code S9152) are limited to once per 30 calendar days, any provider.

ST treatment codes 92507, 92508, and 92526 are payable in 15-minute increments at a maximum of eight units (two hours) per day.

All 15-minute increment procedure codes are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units must be rounded up or down to the nearest quarter hour.

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

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not evenly divisible by 15, minutes greater than 7 are converted to 1 unit and 7 or fewer minutes are converted to 0 unit.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to 1 unit. Consequently, 68 total billable minutes = 5 units of service.

**Refer to:** Section 2.4.3, “Occupational Therapy” in this handbook for the 15-minute conversion table.

ST evaluation and re-evaluations will be denied when billed on the same date of service, any provider as procedure code 92507 and 92508 with modifier GN.

Procedure codes 92526 and 92610 may be considered for treatment and evaluation of swallowing dysfunctions and oral functions for feeding.

Procedure code 97535 is used for ST services for training for augmentative communication devices.

#### 2.4.5.2 Prior Authorization and Documentation Requirements

Prior authorization is required for ST except evaluations and re-evaluations.
The following documentation must be submitted to TMHP prior to the start of care for the current episode of therapy for consideration for prior authorization:

- A current written order by a physician based on medical necessity.
- A prescription is considered current when it is signed and dated on, or no later than, 60 days before the start of therapy.
- A “Request for Initial Outpatient Therapy (Form TP-1)” or “Request for Extension of Outpatient Therapy (Form TP-2) (2 Pages)” must be submitted to TMHP prior to the start of care for the current episode of therapy.
- The most recent evaluation and treatment plan. To establish medical necessity, the written treatment plan must include the following:
  - The age of the client at the time of evaluation.
  - Diagnosis.
  - Description of specific therapy being prescribed.
  - Specific treatment goals related to the client’s individual needs. Therapy goals may include improving function, maintenance of function, or slowing of the deterioration of function.
- For an initial request, anticipated measurable progress toward goals, the prognosis, and the client’s gross motor skills in years or months.
- For a new request for additional therapy, documentation of all progress made from the beginning of the previous treatment period.
- Duration and frequency of therapy.
- Requested date of service.

The number of sessions per week must be supported by documentation supporting the medical necessity for the frequency requested.

When requesting prior authorization for group ST, the provider must submit documentation supporting the group process as being medically necessary and beneficial to the client. When group therapy is authorized, weekly therapy limits will not be exceeded.

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on behalf of the client’s physician when the physician delegates this authority.

A request for ST services may be prior authorized for no longer than 180 days duration. A new request must be submitted if therapy is required for a longer duration. A physician’s prescription is required every 180 days.

The GN modifier is required on all prior authorization requests for ST.

If a provider discontinues therapy with a client and a new provider begins therapy during an existing authorization period, submission of a new plan of care and documentation of the last therapy visit with the previous provider is required along with a letter from the client, or responsible adult, stating the date therapy ended with the previous provider.

### 2.4.6 Claims Information

Providers must submit services provided by CORFs and ORFs in an approved electronic claims format or on the UB-04 CMS-1450 paper claim form from the vendor of their choice. TMHP does not supply the forms.

Revenue and Current Procedural Terminology (CPT) procedure codes are used when submitting claims for CORF and ORF services. The only POS is outpatient facility (POS 5).
Refer to: Form CH.20, “Comprehensive Outpatient Rehabilitation Facility (CORF) (CCP Only)” in this handbook for a claim form example.

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

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


2.4.7 Reimbursement
CORFs and ORFs are reimbursed in accordance with 1 TAC §355.8441.

See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

2.5 Durable Medical Equipment (DME) Supplier (CCP)

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

Home health agencies that provide DME and supplies should refer to subsection 2.1, “Enrollment” in the Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) to enroll as DME–Home Health Services (DMEH) providers.

2.5.1.1 Pharmacies (CCP)
Pharmacy providers are eligible to participate in CCP. To be enrolled in CCP, the pharmacy must also be enrolled in VDP.

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

To locate a pharmacy CCP provider, use the Online Provider Lookup (OPL) at http://opl.tmhp.com/ProviderManager/AdvSearch.aspx.

Refer to: Subsection 2.1.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.

Appendix B: Vendor Drug Program (Vol. 1, General Information).

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

2.5.2 Services, Benefits, and Limitations
Medicaid clients who are birth through 20 years of age are entitled to all medically necessary DME and expendable medical supplies. DME or supplies are medically necessary when required to correct or ameliorate disabilities or physical or mental illnesses or conditions. Any numerical limit on the amount of a particular item of DME or expendable medical supply can be exceeded if medically necessary for Medicaid clients who are birth through 20 years of age. Likewise, time periods for replacement of DME and expendable medical supplies do not apply to Medicaid clients who are birth through 20 years of age if the replacement is medically necessary.
DME is defined as medical equipment that is manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate the client’s disability, condition, or illness.

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

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

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

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

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

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

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

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

Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.

DME repair will be considered based on the age of the item and cost to repair it. A request for repair of DME must include:

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

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

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

Rental reimbursement to the same provider cannot exceed the purchase price, except as addressed in specific policies.
All DME purchased for a client becomes the Medicaid client’s property upon receipt of the item. Delivered equipment will become the Medicaid client’s property in the following instances even though it will not be prior authorized or reimbursed:

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

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

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

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

### 2.5.2.1 Purchase Versus Equipment Rental

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

CCP nurses determine whether the equipment will be rented, purchased, repaired, or modified based on the client’s needs, the duration of use, and the age of the equipment.

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

After prior authorization is obtained for purchase, new equipment must be provided and the rental discontinued. CCP does not purchase used equipment.

Providers of customized or nonbasic medical equipment also must be enrolled as Medicare DME providers.

### 2.5.3 Prior Authorization and Documentation Requirements

Providers can request prior authorization for most DME through the TMHP website. Providers that make written requests for prior authorization must complete Form CH.2, “CCP Prior Authorization Request Form” in this handbook, and they must attach the documentation necessary to support the request. The documentation must include a current prescription that has been signed and dated by a physician (M.D. or D.O.), and it must be mailed or faxed to TMHP with the prior authorization request. For specific policy information not contained in this manual related to the purchase of DME, providers can call TMHP-CCP Customer Service at 1-800-846-7470.

A completed CCP Prior Authorization Request Form prescribing the DME or medical supplies must be signed and dated by the prescribing physician familiar with the client before requesting prior authorization. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates are not accepted. The completed CCP Prior Authorization Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician’s medical record for the client.
To avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of the medical necessity for the equipment and services requested. The physician must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for the mobility aid.

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

A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or expendable medical supply. Physician prescriptions must be specific to the item requested. For example, if the provider is requesting a customized wheelchair, the prescription must request a customized wheelchair, not just a wheelchair. Providers must submit a CCP Prior Authorization Request Form and documentation to support medical necessity to the CCP department before providing services. Providers must obtain prior authorization within three business days of the requested date of service.

2.5.3.1 Equipment Accessories

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

2.5.3.2 Equipment Modifications

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

DME that has been delivered to the client’s home and then found to be inappropriate for the client’s condition will not be eligible for an upgrade within the first six months following purchase. All modifications that are made within the first six months after delivery are considered part of the purchase price. However, CCP may consider prior authorization of modifications to custom equipment if a change occurs in the client’s needs, capabilities, or physical or mental status that cannot be anticipated. Documentation must include:

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

2.5.3.3 Equipment Adjustments

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

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

2.5.3.4 Equipment Repairs

Repairs require replacement of components that are no longer functional. Repairs to client-owned equipment may be considered for reimbursement with prior authorization through CCP. Technician fees are considered part of the cost of the repair. Providers must use procedure code K0739.

Repairs for non-warranty DME may be billed using procedure code K0739. Non-warranty DME repairs will require prior authorization. Providers are responsible for maintaining documentation in the client’s medical record that specifies the repairs and supporting medical necessity.
Rentals may be considered for reimbursement during the repair period of the client’s owned equipment. Routine maintenance of rental equipment is the provider’s responsibility.

2.5.3.5 **DME Certification and Receipt Form**

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver.

The DME provider must maintain the signed and dated form in the client’s medical record.

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

Refer to: Form CH.5, “DME Certification and Receipt Form (3 Pages)” in this handbook.

2.5.3.6 **Documentation of Supply Delivery**

Providers must retain individual delivery slips or invoices for each date of service to document the date of delivery for all supplies provided to a client. Providers must disclose this documentation to HHSC or its designee upon request. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until all audit questions, appeals, hearings, investigations, or court cases are resolved. The DOS is the date on which supplies are delivered to the client or shipped by a carrier to the client as evidenced by the dated tracking document attached to the invoice for that date.

Documentation of delivery must include one of the following:

- Delivery slip or invoice signed and dated by the client or caregiver.
- A dated carrier tracking document that includes the shipping date and delivery date must be printed from the carrier’s website as confirmation that the supplies were shipped and delivered. The dated carrier tracking document must be attached to the delivery slip or invoice.

The dated delivery slip or invoice must include the client’s full name and address to where supplies were delivered, and an itemized list of goods that includes the descriptions and numerical quantities of the supplies delivered to the client. This document could also include prices, shipping weights, shipping charges, and any other description.

All claims submitted for DME supplies must include the same quantities or units that are documented on the delivery slip or invoice and on the CCP Prior Authorization Request form. They must reflect the number of units by which each product is measured. For example, diapers are measured as individual units. If one package of 300 diapers is delivered, the delivery slip or invoice and the claim must reflect that 300 diapers were delivered and not that one package was delivered. Diaper wipes are measured as boxes or packages. If one box of 200 wipes is delivered, the delivery slip or invoice and the claim must reflect that one box was delivered and not that 200 individual wipes were delivered. There must be one dated delivery slip or invoice for each claim submitted for each patient. All claims submitted for DME supplies must reflect the same date as the delivery slip or invoice and the same timeframe covered by the CCP Prior Authorization Request form. The DME Certification and Receipt Form is still required for all equipment delivered.

2.5.3.7 **Specific CCP Policies**

Most DME and expendable medical supplies are available under Texas Medicaid (Title XIX) Home Health Services. If the service is not available under Texas Medicaid (Title XIX) Home Health Services, CCP may cover the requested service, if the client is CCP-eligible and the service is medically necessary, requested by a physician, and for which FFP is available.
**Refer to:** Form DM.1, “DME Certification and Receipt Form (4 pages)” in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (Vol. 2, Provider Handbooks).

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

### 2.5.4 Blood Pressure Devices

#### 2.5.4.1 Services, Benefits, and Limitations

The following blood pressure devices and their components are benefits of CCP in the home setting for self-monitoring when the equipment is prescribed by a physician:

- **Manual blood pressure device.** A device that requires manual cuff inflation with real-time visualization of the results displayed on the manometer.

- **Automated blood pressure device.** A device that inflates the cuff manually or automatically and displays the blood pressure results on a small screen.

  **Note:** Finger cuff automated blood pressure devices for diagnostic purposes are not a benefit of Texas Medicaid.

- **Hospital-grade blood pressure device.** A device that includes memory for continuous recording, has an alarm system to notify the caregiver of abnormal readings, and is capable of frequent or continuous automatic blood pressure and heart rate monitoring with correction of motion artifact.

Documentation that supports medical necessity of the requested equipment, including the diagnosis, must be maintained in the client’s medical record and is subject to retrospective review.


#### 2.5.4.1.1 Manual and Automated Blood Pressure Devices

Providers must use procedure code A4660 or A4670 when billing for manual or automated blood pressure devices.

Manual and automated blood pressure devices that have been purchased are anticipated to last a minimum of one year and may be considered for replacement when one year has passed or when the equipment is not functional and not repairable.

Manual and automated blood pressure devices may be reimbursed when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4010</td>
</tr>
<tr>
<td>40300</td>
</tr>
<tr>
<td>40411</td>
</tr>
<tr>
<td>40519</td>
</tr>
<tr>
<td>4168</td>
</tr>
<tr>
<td>4254</td>
</tr>
<tr>
<td>42651</td>
</tr>
<tr>
<td>4270</td>
</tr>
<tr>
<td>42822</td>
</tr>
</tbody>
</table>
2.5.4.1.2 Hospital-Grade Blood Pressure Devices

Providers must use procedure code A9279 with modifier U1 when billing for hospital-grade blood pressure devices.

Hospital-grade blood pressure devices that have been purchased are anticipated to last a minimum of three years and may be considered for replacement when three years have passed or when the equipment is not functional and not repairable.

For clients who are birth through 11 months of age, the rental or purchase of a hospital-grade blood pressure device is a benefit when documentation supports medical necessity and includes an explanation of why the client cannot use a standard automated blood pressure device.

For clients who are 12 months of age and older, the rental or purchase of a hospital-grade blood pressure device is a benefit on a case-by-case basis. Supporting documentation of medical necessity must be provided.

The following indications are recognized by Texas Medicaid for hospital-grade blood pressure devices:

- Hypotension
- Essential hypertension
- Hypertensive heart disease
- Hypertensive renal disease
- Acute pulmonary heart disease
- Chronic pulmonary heart disease
- Cardiomyopathy
- Conduction disorders
- Cardiac dysrhythmias
- Heart failure
- Acute kidney failure
- Chronic kidney disease
- Hydronephrosis
- Vesicoureteral reflux with neuropathy
- Bulbus cordis anomalies and anomalies of cardiac septal closure

All rental costs of the hospital-grade blood pressure device apply toward the purchase price.

2.5.4.1.3 Blood Pressure Device Components, Replacements, and Repairs

The following may be considered for reimbursement of blood pressure device:

- Replacement of blood pressure cuffs (procedure code A4663)
• Replacement of other components (procedure code A4660)
• Repairs of the equipment (procedure code A4660)

2.5.4.2 Prior Authorization and Documentation Requirements

A CCP Prior Authorization Request Form, signed and dated by the physician, must be submitted with the documentation supporting medical necessity for the device. Supporting documentation of medical necessity must include the diagnosis.

2.5.4.2.1 Manual and Automated Blood Pressure Devices

Prior authorization is not required for manual and automated blood pressure devices except when the following situations apply:

• Another blood pressure device is medically necessary within the same year. Replacement of equipment within the same year as the purchase requires prior authorization. When equipment needs to be replaced sooner than the anticipated lifespan, the provider must submit a copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence.

• The client has a diagnosis code other than those in the diagnosis table listed above. If the client has a diagnosis code other than those listed in the above table, a request for prior authorization for an initial or replacement device with all necessary documentation supporting medical necessity of the blood pressure device.

2.5.4.2.2 Hospital-Grade Blood Pressure Devices

Prior authorization is required for the rental or purchase of a hospital-grade blood pressure device. A determination will be made by HHSC or its designee as to whether the equipment will be rented, purchased, repaired, or modified based on the client’s needs, duration of use, and age of the equipment. Repairs and modifications can only be performed on purchased equipment.

Documentation of medical necessity for the hospital-grade blood pressure device must support the client’s need for self-monitoring and address why an automated blood pressure device will not meet the client’s needs. The documentation must include:

• All pertinent diagnoses.
• Initial evaluation.
• Symptoms.
• Duration of symptoms.
• Any recent hospitalizations (within past 12 months).
• Comorbid conditions.
• How frequent or continuous self-monitoring will affect treatment.
• All pertinent laboratory and radiology results.
• Client’s weight.
• A family or caregiver(s) who has an understanding of cause and effect and object permanence and who has agreed to accept the responsibility to be trained to use the hospital-grade monitor.

Prior authorization may be granted for a six-month rental period when the request is submitted with documentation of medical necessity supporting the client’s need for self-monitoring and addressing why an automated blood pressure device will not meet the client’s needs.

Recertification for an additional six-month period may be considered when the physician provides current documentation that supports the ongoing medical necessity for self-monitoring and confirms the client or family is compliant with its use.
A hospital-grade blood pressure device will not be considered for prior authorization of purchase until the client has completed a six-month trial period.

Purchase of a hospital-grade blood pressure device may be prior authorized when all of the following criteria are met:

- The client is 12 months of age or older.
- Documentation of medical necessity supports the client’s need for ongoing self-monitoring and addresses why an automated blood pressure device will not meet the client’s needs.

2.5.4.2.3 Blood Pressure Device Components, Replacements, and Repairs

Replacement of blood pressure cuffs and other components may be considered for purchase with prior authorization and documentation of medical necessity that explains the need for the replacement.

Repair of equipment must be prior authorized when irreparable damage has occurred and documentation exists that supports the need for repair. Repair of equipment will be considered after the factory warranty has expired.

2.5.5 Cardiorespiratory (Apnea) Monitor

2.5.5.1 Services, Benefits, and Limitations

Apnea monitors are a benefit of CCP for clients who are birth through 20 years of age. The purchase of an apnea monitor (procedure code E0618 or E0619) is limited to once every five years. The rental of an apnea monitor (procedure code E0619) is limited to once per month.

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

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>33700 33709</td>
</tr>
<tr>
<td>4260 42610</td>
</tr>
<tr>
<td>42611 42612</td>
</tr>
<tr>
<td>42613 4270</td>
</tr>
<tr>
<td>4272 42789</td>
</tr>
<tr>
<td>53081 74686</td>
</tr>
<tr>
<td>7707 77081</td>
</tr>
<tr>
<td>77082 77083</td>
</tr>
<tr>
<td>77084 77089</td>
</tr>
<tr>
<td>77981 77982</td>
</tr>
<tr>
<td>7850 78603</td>
</tr>
<tr>
<td>V198</td>
</tr>
</tbody>
</table>

Diagnosis code 42789 includes atrial tachycardia (supraventricular tachycardia [SVT], atrioventricular [AV] nodal re-entry, nodal, and sinoauricular) and bradycardia (nodal, sinoatrial).

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

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

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

The apnea monitor and pulse oximeter combination device is not a benefit of Texas Medicaid.
2.5.5.2 Prior Authorization and Documentation Requirements

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

Prior authorization is required for rental of an apnea monitor, and may be considered for clients who are birth through 20 years of age that are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client’s disability or physical or mental illness or condition. Documentation must include one of the following:

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

Clients who are five months of age and older must have demonstrated an apparent life-threatening event, tracheostomy, anatomic abnormality of the airway, chronic lung disease requiring oxygen or ventilatory support, or other diagnoses based on documented medical necessity.

Prior authorization must be obtained in writing and must include all of the following:

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

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

2.5.6 Pulse Oximeter

2.5.6.1 Services, Benefits, and Limitations

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

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

A pulse oximeter may be reimbursed for purchase once every five years.

The provider is responsible for retaining a current prescription.

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

2.5.6.2 Prior Authorization and Documentation Requirements

A pulse oximeter requires prior authorization.

A pulse oximeter may be considered for prior authorization for clients who are birth through 20 years of age who are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client’s disability or physical or mental illness or condition. Documentation must include the following for the level requested:

- **Level One.** Basic level monitoring capable of spot checks and heart rate or capable of continuous monitoring, alarm, memory, and correction of motion artifact. Applicable if there is a caregiver or
medical provider identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way and the client meets at least one of the following criteria:

- Client is oxygen- or ventilator-dependent (up to 16 hours per day).
- Client is clinically stable and able to wean from oxygen or ventilator.
- Client has other medically necessary condition(s) requiring monitoring of oxygen saturation or needs continuous monitoring of oxygen saturation during sleep or to maintain optimal levels.

**Level Three.** Providers must use modifier TG if the oximeter device is for a serious condition and there is critical need for continuous monitoring. Applicable if the client meets all the following criteria:

- Client has frequent need for changes in oxygen and ventilator settings.
- Client is oxygen- or ventilator-dependent (e.g., 16 to 24 hours per day).
- Client is in the weaning process from oxygen or ventilator and experiencing respiratory complications.
- Client requires equipment that is motion-sensitive or that has more complex readouts or monitoring capabilities.
- There is a caregiver or medical provider identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way.

For all requests providers must:

- Submit the completed Form CH.10, "Pulse Oximeter Form" and Form CH.2, "CCP Prior Authorization Request Form" in this handbook.
- Clearly indicate medical necessity using the TG modifier on the Pulse Oximeter Form.
- Continue to use the current code for lease (E0445 with modifier RR) and purchase (E0445 with modifier NU).

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

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

2.5.7 Diabetic Equipment and Supplies

**Note:** This section is only for tubeless external insulin infusion pumps.

Refer to: Subsection 2.2.11, “Diabetic Equipment and Supplies” in the Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2 Provider Handbooks) for all other diabetic equipment and supplies, including the external insulin pump.

2.5.7.1 Services, Benefits, and Limitations

The tubeless external insulin infusion pump and supplies are a benefit of Texas Medicaid through CCP. The tubeless external insulin pump must be ordered by, and the client’s follow-up care must be managed by, a prescribing provider who has experience managing clients with insulin infusion pumps and who is knowledgeable in the use of insulin infusion pumps.

Providers must use procedure code E0784 and modifier U1 for the rental or purchase of the tubeless external insulin pump and procedure code A9274 for the tubeless external insulin pump supplies. Procedure code A9274 is limited to 15 per month.
A tubeless external insulin pump that has been purchased is expected to last a minimum of three years and may be considered for replacement when three years have passed or the equipment is no longer repairable. The replacement of the equipment may also be considered when it has been lost or irreparably damaged. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent a reoccurrence must be submitted. Additional services may be considered based on documentation of medical necessity.

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

### 2.5.7.2 Prior Authorization and Documentation Requirements

Prior authorization is required for the tubeless external insulin pump with carrying cases and related supplies and repairs. The tubeless external insulin pump supplies may be considered separately when a tubeless external insulin pump is rented.

The tubeless external insulin pump and supplies may be obtained through one of the following methods:

- **CCP Prior Authorization Request Form.** The completed CCP Prior Authorization Request Form must be maintained by the dispensing provider and the prescribing physician in the client’s medical record. The physician must maintain the original signed and dated copy of the CCP Prior Authorization Request Form. The completed CCP Prior Authorization Request Form is valid for a period up to six months from the physician’s signature date.

- **Verbal or detailed written order.** The verbal or detailed written order must be provided by a physician, PA, NP, CNS, or a CNM.

If the dispensing provider does not have a detailed written order, a verbal order is required to be on file until the written order is received from the prescribing provider and before providing diabetic equipment and supplies. The prescribing provider’s order may be a written, fax, electronic, or verbal order and must include:

- A description of the item(s).
- The client’s name.
- The name of the physician or authorized prescribing provider.
- The date of the order.

A detailed written order must be received by the DME supplier within 90 days from the date of the prescribing provider’s signature. For initial orders, the detailed written order for diabetic equipment and supplies is valid for six months from the date of the order or the date of the prescribing provider’s signature, whichever is earlier. For renewal orders the detailed written order is valid for six months from the start date, or in absence of a start date, the date of the authorized prescribing signature.

#### 2.5.7.2.1 Tubeless External Insulin Pump Rentals

Tubeless external insulin pump rentals may be considered for prior authorization with the submission of clinical documentation that indicates one of the following:

- The client has a diagnosis of type 1 or type 2 diabetes and meets at least two of the following criteria while on multiple daily injections of insulin:
  - Elevated glycosylated hemoglobin level (HbA1c) > 7.0 percent.
  - A history of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl.
  - A history of severe glycemic excursions with wide fluctuations in blood glucose.
  - A history of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness.
  - Expectation of becoming pregnant within three months.
- The client has a diagnosis of gestational diabetes and meets at least one of the following criteria:
  - Erratic blood sugars in spite of maximal compliance and split dosing.
  - Other evidence that adequate control is not being achieved by current methods.

In addition to the clinical documentation, the provider must submit an External Insulin Pump form that indicates:

- The client or caregiver possesses:
  - The cognitive and physical abilities to use the recommended insulin pump treatment regimen.
  - An understanding of cause and effect.
  - The willingness to support the use of the external insulin pump.

- The prescribing provider has attested that:
  - A training and education plan will be completed prior to initiation of pump therapy.
  - The client or caregiver will be given face-to-face education and instruction and will be able to demonstrate the necessary proficiency to integrate insulin pump therapy with their current treatment regimen for ambient glucose control.

The External Insulin Pump form has been updated to incorporate the required prior authorization criteria for the rental of the external insulin pump.

### 2.5.7.2.2 Purchase of Tubeless External Insulin Pump

The purchase of a tubeless external insulin pump may be considered for prior authorization after it has been rented for a three-month trial and all of the following documentation has been provided:

- The training or education plan has been completed.
- The pump is the appropriate equipment for the specific client.
- The client is compliant with the use of the pump.

### 2.5.8 Donor Human Milk

#### 2.5.8.1 Services, Benefits, and Limitations

Donor human milk is a benefit of CCP for clients who are birth through 11 months of age who are CCP-eligible when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client’s disability or physical or mental illness or condition. Documentation must include all of the following:

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

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

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

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

Donor human milk is only reimbursed to a Texas Medicaid-enrolled donor milk bank and only for children who are in the home setting.
The physician must address the benefits and risks of using donor human milk, such as HIV, freshness, effects of pasteurization, nutrients, and growth factors to the parent. The physician also must address donor screening, pasteurization, milk storage, and transport of the donor milk. The physician may obtain this information from the donor milk bank.

**2.5.8.2 Prior Authorization and Documentation Requirements**

Donor human milk may be considered for a maximum of six months per authorization. The authorization may be extended with documentation of medical necessity.

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

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

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

Texas Medicaid & Healthcare Partnership  
Comprehensive Care Program (CCP)  
PO Box 200735  
Austin, TX 78720-0735  
Fax: (512) 514-4212

The documentation of medical necessity and appropriateness and the signed and dated written informed consent form must be maintained in the client’s clinical records. The documentation of medical necessity must be completed by the physician ordering the donor human milk. The clinical records are subject to retrospective review. The documentation must address all of the following:

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

Refer to: Form CH.6, “Donor Human Milk Request Form” in this handbook.  
Form CH.2, “CCP Prior Authorization Request Form” in this handbook.

**2.5.9 Incontinence Supplies**

**2.5.9.1 Services, Benefits, and Limitations**

Incontinence supplies, such as diapers, briefs, pull-ons, liners, wipes, and underpads, may be considered for reimbursement through CCP for those clients who are birth through 3 years of age with a medical condition resulting in an increased urine or stool output beyond the typical output for this age group, such as celiac disease, short bowel syndrome, Crohn’s disease, thymic hypoplasia, Acquired Immunodeficiency Syndrome (AIDS), congenital adrenal hyperplasia, diabetes insipidus, Hirschsprung’s disease, or radiation enteritis.
For clients who are 4 years of age and older, incontinence supplies may be considered through Title XIX Home Health Services when their medical condition results in an impairment of urination and/or stool. For clients who do not meet criteria through Title XIX Home Health Services, incontinence supplies may be considered through CCP with documentation of medical necessity.

Lack of bladder or bowel control is considered normal development for clients who are 4 years of age or younger.

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

2.5.9.1.1 Skin Sealants, Protectants, Moisturizers, Ointments

Skin sealants, protectants, moisturizers, and ointments may be considered for clients with documented incontinence-associated dermatitis.

Note: Skin sealants, protectants, moisturizers, and ointments for diagnoses other than incontinence-associated dermatitis (e.g., wounds, decubitus ulcers, periwound skin complications, peristomal skin complications) may be considered for prior authorization through home health services wound care supplies and systems.

Incontinence-associated dermatitis is classified using the following categories:

- **Category 1.** A small area of skin breakdown (less than 20 cm2) with mild redness (blotchy and non-uniform) and mild erosion involving the epidermis only.
- **Category 2.** A moderate area of skin breakdown (20 cm2 through 50 cm2) with moderate redness (severe in spots, but not uniform in appearance) and moderate erosion involving epidermis and dermis with no or little exudate.
- **Category 3.** A large area of skin breakdown (greater than 50 cm2) with severe redness (uniformly severe in appearance) and severe erosion of epidermis with moderate involvement of the dermis and no or small volume of exudate.
- **Category 4.** A large area of skin breakdown (greater than 50 cm2) with severe redness (uniformly severe in appearance) and extreme erosion of epidermis and dermis with moderate volume of persistent exudate.

The category of incontinence-based dermatitis determines the benefit limitation and whether to use a modifier when submitting a claim for procedure code A6250, as shown in the following table:

<table>
<thead>
<tr>
<th>Dermatitis Category</th>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Benefit Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1 or 2</td>
<td>A6250</td>
<td>UA</td>
<td>Up to 2 containers (no less than 4 ounces per container) of skin sealants, protectants, moisturizers, and ointments per month.</td>
</tr>
<tr>
<td>Category 3 or 4</td>
<td>A6250</td>
<td>None</td>
<td>Skin sealants, protectants, moisturizers, and ointments may be considered.</td>
</tr>
</tbody>
</table>

2.5.9.1.2 Diapers, Briefs, and Liners

The following procedure codes must be used when billing for diapers, briefs, and liners and are limited to a combined total of 240 per month:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>T4521</td>
<td>T4522</td>
</tr>
<tr>
<td>T4523</td>
<td>T4524</td>
</tr>
<tr>
<td>T4525</td>
<td>T4526</td>
</tr>
<tr>
<td>T4527</td>
<td>T4528</td>
</tr>
<tr>
<td>T4529</td>
<td>T4530</td>
</tr>
<tr>
<td>T4531</td>
<td>T4532</td>
</tr>
<tr>
<td>T4533</td>
<td>T4534</td>
</tr>
<tr>
<td>T4535</td>
<td>T4536</td>
</tr>
</tbody>
</table>
2.5.9.1.3 Diaper Wipes
Diaper wipes may be considered for clients who are receiving diapers, briefs, or pull-ons through CCP. Providers must use procedure code A4335 and modifier U9 when billing for diaper wipes. Procedure code A4335 is limited to 2 boxes per month.

2.5.9.1.4 Underpads
Underpads may be considered for clients who are receiving diapers, briefs, or pull-ons through CCP. Providers must use procedure code A4554 when billing for underpads. Procedure code A4554 is limited to 120 per month.

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

The following procedure codes must be used when billing for external urinary collection devices:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4326</td>
<td>31 per month</td>
</tr>
<tr>
<td>A4327</td>
<td>4 per month</td>
</tr>
<tr>
<td>A4328</td>
<td>4 per month</td>
</tr>
<tr>
<td>A4349</td>
<td>31 per month</td>
</tr>
</tbody>
</table>

2.5.9.2 Prior Authorization and Documentation Requirements
Prior authorization is required for incontinence supplies through CCP.

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

Additional quantities may be considered with documentation of medical necessity.

The quantity of incontinence supplies billed for a one-month period must be consistent with the number of times per day the physician has ordered the supply be used on the CCP Prior Authorization Request Form.

To request prior authorization for incontinence supplies, the following documentation must be provided for the items requested:

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

Additional information may be requested to clarify or complete a request for the supplies and equipment.
2.5.10 Mobility Aids

2.5.10.1 Services, Benefits, and Limitations

Mobility aids and related supplies, including, but not limited to, strollers, special-needs car seats, and travel safety restraints are a benefit to assist clients to move about in their environment when medically necessary and Federal Financial Participation is available.

Mobility aids and related supplies may be considered for reimbursement through CCP for clients who are birth through 20 years of age who are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client’s disability or physical or mental illness or condition. Documentation must include the following:

- The client’s mobility status would be compromised without the requested equipment.
- The requested equipment or supplies are safe for use in the home.

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

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

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

2.5.10.1.1 Portable Client Lifts for Outside the Home Setting

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

2.5.10.1.2 Wheeled Mobility Systems

A wheeled mobility system is a manual or power wheelchair, or scooter that is a customized power or manual mobility device, or a feature or component of the mobility device, including, but not limited to, the following:

- Seated positioning components
- Manual seating options
- Adjustable frame
- Other complex or specialized components

A stroller (a multipositional client transfer system with integrated seat, operated by caregiver) for medical needs may be considered for clients who are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client’s disability or physical or mental illness or condition. Documentation must include the following:

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

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

Scooters may be considered for reimbursement through Texas Medicaid (Title XIX) Home Health Services.
Definitions and Responsibilities
The following definitions and responsibilities apply to the provision of wheeled mobility systems:

Adjustments. The adjustment of a component or feature of a wheeled mobility system. Adjustments require labor only and do not include the addition, modification, or replacement of components or supplies needed to complete the adjustment.

Texas Medicaid will consider adjustments only to client-owned equipment that is considered a benefit of Texas Medicaid.

Major Modification. The addition of a custom or specialized feature or component of a wheeled mobility system that did not previously exist on the system due to changes in the client’s needs, including but not limited to, the items listed in this paragraph. This definition also includes the modification of a custom or specialized feature or component due to a change in the client’s needs, including but not limited to, the following:

- Seated positioning components including, but not limited to, specialized seating or positioning components
- Powered or manual seating options including, but not limited to, power tilt or recline seating systems and seat elevation systems
- Specialty driving controls including, but not limited to, nonstandard alternative power drive control systems
- Adjustable frame including, but not limited to, nonstandard seat frame dimensions
- Other complex or specialized components including, but not limited to, power elevating leg rests and specialized electronic interfaces

The replacement of a previously existing custom or specialized feature or component with an identical or comparable component is considered a repair and not a major modification.

Texas Medicaid will consider major modifications only to client-owned equipment that is considered a benefit of Texas Medicaid.

Minor Modification. The addition or modification of non-custom or non-specialized features or components due to changes in the client’s needs, including but not limited to, the following:

- Armpads/armrests
- Legrests/Leg extensions
- Modification of seating and positioning components to accommodate for a change in the client’s size.

The replacement of a previously existing noncustom or nonspecialized feature or component with an identical or comparable component is considered a repair and not a minor modification.

Texas Medicaid will consider minor modifications only to client-owned equipment that is considered a benefit of Texas Medicaid.

Mobility Related Activity to Daily Living (MRADL). An activity of daily living that requires the use of mobility aids (i.e., toileting, feeding, dressing, grooming, and bathing).

Occupational Therapist. A person who is currently licensed by the Executive Council of Physical Therapy & Occupational Therapy Examiners to practice OT.

Physical Therapist. A person who is currently licensed by the Executive Council of Physical Therapy & Occupational Therapy Examiners to practice PT.

Note: An occupational or physical therapist is responsible for completing the required seating assessment for a client to obtain a wheeled mobility system.
Qualified Rehabilitation Professional (QRP). A QRP is a person who meets one or more of the following criteria:

- Holds a certification as an Assistive Technology Professional (ATP) or a Rehabilitation Engineering Technologist (RET) issued by, and in good standing with, the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).
- Holds a certification as a Seating and Mobility Specialist (SMS) issued by, and in good standing with, RESNA.
- Holds a certification as a Certified Rehabilitation Technology Supplier (CRTS) issued by, and in good standing with, the National Registry of Rehabilitation Technology Suppliers (NRRTS).
- The QRP is responsible for:
  - Being present at and involved in the seating assessment of the client for the rental or purchase of a wheeled mobility system.
  - Being present at the time of delivery of the wheeled mobility system to direct the fitting of the system to ensure that the system functions correctly relative to the client.

Repairs. The replacement of a component or feature of a wheeled mobility system with an identical or comparable component that does not change the size or function of the system due to the component no longer functioning as designed.

Texas Medicaid will consider repairs only to client-owned equipment that is considered a benefit of Texas Medicaid.

2.5.10.1.3 Seating Assessment

A seating assessment is required for the rental or purchase of any device meeting the definition of a wheeled mobility system or purchase of any device meeting the definition of a wheelchair for a client with a congenital or neurological condition, myopathy, or skeletal deformity that requires the use of a wheelchair as defined under subsection 2.5.10.1.2, “Wheeled Mobility Systems” in this handbook.

A seating assessment with measurements, including specifications for exact mobility and seating equipment and all necessary accessories, must be completed by a physician, licensed occupational therapist, or licensed physical therapist.

A QRP directly employed or contracted by the DME provider must be present at, and participate in all seating assessments, including those provided by a physician.

Upon completion of the seating assessment, the QRP must attest to his or her participation in the assessment by signing the Wheelchair/Scooter/Stroller Seating Assessment Form. This form must be submitted with all requests for wheeled mobility systems.

When the practitioner completing the seating assessment is an occupational therapist or physical therapist, the occupational therapist or physical therapist may perform the seating assessment as the therapist, or as the QRP, but may not perform in both roles at the same time. If the occupational therapist or physical therapist is attending the seating assessment as the QRP, the occupational therapist or physical therapist must meet the credentialing requirements and be enrolled in Texas Medicaid as a QRP.

If the seating assessment is completed by a physician, reimbursement is considered part of the physicians office visit and will not be reimbursed separately.

The practitioner (occupational therapist or physical therapist) completing the assessment must submit procedure code 97001 or 97003 with modifier U1, to bill for the seating assessment.
Services for the QRP’s participation in the seating assessment must be submitted for reimbursement by the DME provider billing for the wheeled mobility system using procedure code 97542 with modifier U1. The DME provider must include the QRP specialty as the performing provider on the claim for all components of the wheeled mobility system, including the QRP’s participation in the seating assessment.

**Note:** Seating assessment services performed by a QRP are limited to four units (one hour).

### 2.5.10.1.4 Fitting of Custom Wheeled Mobility Systems

The fitting of a wheeled mobility system is defined as the time the QRP spends with the client fitting the various systems and components of the system to the client. It may also include time spent training the client or caregiver in the use of the wheeled mobility system. Time spent setting up the system, or travel time without the client present, is not included.

A fitting is required for any device meeting the definition of a wheeled mobility system as defined under subsection 2.5.10.1.2, “Wheeled Mobility Systems” in this handbook.

The fitting of a wheeled mobility system must be:

- Performed by the same QRP that was present for, and participated in, the seating assessment of the client.
- Completed prior to submitting a claim for reimbursement of a wheeled mobility system.

The QRP performing the fitting will:

- Verify the wheeled mobility system has been properly fitted to the client.
- Verify that the wheeled mobility system will meet the client’s functional needs for seating, positioning, and mobility.
- Verify that the client, parent, guardian of the client, and/or caregiver of the client has received training and instruction regarding the wheeled mobility system’s proper use and maintenance.

The QRP must complete and sign the DME Certification and Receipt form after the wheeled mobility system has been delivered and fitted to the client. Completion of this form by the QRP signifies that all components of the fitting as outlined above have been satisfied. The form must be completed prior to submission of a claim for a wheeled mobility system, and submitted to HHSC’s designee according to instructions on the form to allow for proper claims processing.

Services for fitting of a wheeled mobility system by the QRP must be submitted for reimbursement by the DME provider of the wheeled mobility system using procedure code 97542 with modifier U2. The DME provider must list the QRP who participated in the seating assessment as the performing provider on the claim for all components of the wheeled mobility system, including the fitting performed by the QRP.

Procedure code 97542 with modifier U2 must be billed on the same claim as the procedure code(s) for the wheeled mobility system in order for both services to be reimbursed.

### 2.5.10.1.5 Modifications, Adjustments, and Repairs

Major and minor modifications, adjustments, and repairs to standard mobility aid equipment within the first six months after delivery are considered part of the purchase price.

Modifications, adjustments, and repairs, as well as the associated services by the QRP for the seating assessment and fitting, within the first six months after delivery are considered part of the purchase price.

Major modifications to a wheeled mobility system requires the completion of a new seating assessment by a qualified practitioner (physician, physical therapist, or occupational therapist), with the participation of a QRP.
Minor modifications, adjustments, or repair to a wheeled mobility system does not require the completion of a new seating assessment.

A wheeled mobility system that has been fitted and delivered to the client’s home by a QRP and then found to be inappropriate for the client’s condition will not be eligible for an upgrade, replacement, or major modification within the first six months following purchase unless there has been a significant change in the client’s condition. The significant change in the client’s condition must be documented by a physician familiar with the client.

Claims submitted for equipment provided as a minor modification or repair to a wheeled mobility system must be submitted with modifier RB.

2.5.10.1.6 Stroller Ramps—Portable and Threshold

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

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

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

Providers must use procedure code E1399 for the purchase of portable and threshold stroller ramps.

2.5.10.1.7 Feeder Seats, Floor Sitters, Corner Chairs, and Travel Chairs

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

2.5.10.1.8 Special-Needs Car Seats

A special-needs car seat may be considered for a client who has outgrown an infant car seat and is unable to travel safely in a booster seat or seat belt.

A special-needs car seat for a client who does not meet the criteria may be considered on a case-by-case basis with documentation of medical necessity upon review by the state or its designee.

Providers must use procedure code E1399 for the purchase of a special-need car seat.

2.5.10.1.9 Travel Safety Restraints

A travel safety restraint and ankle or wrist belts may be considered for clients with a medical condition requiring transportation in either a prone or supine position. The DME provider and the prescribing physician familiar with the client must maintain documentation in the client’s medical record supporting the medical necessity of the travel safety restraint.

Providers must use procedure code E0700 for the purchase of travel safety restraints, including ankle and wrist belts.

2.5.10.2 Prior Authorization and Documentation Requirements

Prior authorization is required for all mobility aids and related services, except travel safety restraints for clients with a medical condition requiring them to be transported in either a prone or supine position.

Mobility aid equipment that has been purchased is anticipated to last a minimum of five years and may be considered for replacement with prior authorization when five years have passed or the equipment is no longer repairable. Prior authorization for replacement of mobility aid equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent recurrence must be submitted.
When prior authorization of a mobility aid replacement is requested before five years have passed, the following information must be submitted with the request:

- A statement from the prescribing physician or licensed occupational therapist or physical therapist stating that the equipment no longer meets the client’s needs
- Documentation supporting why the equipment no longer meets the client’s needs

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

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

2.5.10.2.1 Portable Client Lifts for Outside the Home Setting

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

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

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

2.5.10.2.2 Wheeled Mobility System

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

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

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

- **Level One, Basic Stroller.** The client meets the criteria for a stroller. Providers must use procedure code E1035.
- **Level Two, Stroller with Tray for Oxygen or Ventilator.** The client meets the criteria for a level-one stroller and is oxygen- or ventilator-dependent. Providers must use procedure code E1035 with modifier TF.
- **Level Three, Stroller with Positioning Inserts.** The client meets the criteria for a level-one or level-two stroller and requires additional positioning support. Providers must use procedure code E1035 with modifier TG.
The following supporting documentation must be submitted:

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

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

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

2.5.10.2.3 Modifications

Modifications to custom equipment after the first six months from fitting and delivery may be considered for prior authorization should a change occur in the client’s needs, capabilities, or physical and mental capability, which cannot be anticipated.

Documentation supporting the medical necessity of the requested modification must include the following:

- Description of the change in the client’s condition that requires accommodation by different seating, drive controls, electronics, or other mobility base components.

- All projected changes in the client’s mobility needs.

- The date of purchase, the serial number of the current equipment, and the cost of purchasing new equipment versus modifying current equipment.

Major modifications to a wheeled mobility system also require that a new seating assessment be completed and submitted with the prior authorization request. A request for authorization of the QRP’s participation in the seating assessment for the major modification must be included with the prior authorization request for the major modification.

Minor modifications to a wheeled mobility system do not require the completion of a new seating assessment.

Requests for equipment submitted as a minor modification to a wheeled mobility system must be submitted with modifier RB.

2.5.10.2.4 Adjustments

Adjustments within the first six months after delivery, including adjustments to a wheeled mobility system within the first six months after fitting and delivery by a QRP will not be prior authorized.

A seating or positioning component alteration to accommodate a change in the client’s size (height or weight) that does not require replacement components is considered an adjustment and not a major modification.

A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months from delivery.

Documentation must include the date of purchase, the serial number of the current equipment, and the reason for adjustments.

2.5.10.2.5 Repairs

Repairs to client owned equipment may be considered for prior authorization, as needed, with documentation of medical necessity. Technician fees are considered part of the cost of the repair.
HHSC or its designee reserves the right to request additional documentation about the need for repairs when there is evidence of abuse or neglect to equipment by the client, client’s family or caregiver. Requests for repairs when there is documented proof of abuse or neglect will not be authorized.

Requests for equipment submitted as a repair to a wheeled mobility system must be submitted with modifier RB.

Providers are responsible for maintaining documentation in the client’s medical record specifying the repairs and supporting medical necessity.

Documentation must include the date of purchase and serial number of the current equipment, the cause of the damage or need for repairs, the steps the client or caregiver will take to prevent further damage if repairs are due to an accident and, when requested the cost of purchasing new equipment as opposed to repairing current equipment.

2.5.10.2.6 Seating Assessments

A seating assessment performed by an occupational therapist, physical therapist, or a physician, with the participation of a QRP, does not require prior authorization. A seating assessment performed by a physician is considered part of the physician E/M service.

A seating assessment must be completed by a physician or licensed occupational therapist or physical therapist, who is not employed by the equipment supplier, before requesting prior authorization.

The seating assessment must clearly show that the equipment is medically necessary and will correct or ameliorate the client’s disability or physical or mental illness or condition.

The QRP’s participation in the seating assessment requires authorization before the service can be reimbursed. Authorization must be requested at the same time and on the same prior authorization request form as the prior authorization request for the QRP fitting and the wheeled mobility system or major modification to the wheeled mobility system.

- Prior authorization requests for the QRP’s participation in the seating assessment will be returned to the provider if the seating assessment is requested separately from the prior authorization for the QRP fitting and the wheeled mobility system or major modification to the wheeled mobility system.

- The QRP participating in the seating assessment must be directly employed by, or contracted with, the DME provider requesting the wheeled mobility system or major modification to a wheeled mobility system.

- An authorization for the QRP’s participation in the seating assessment for a wheeled mobility system or major modification to a wheeled mobility system may be issued to the QRP in 15-minute increments, for a time period of up to one hour (4 units).

Documentation must include the following:

- Explain how the family will be trained in the use of the equipment.

- Anticipate changes in the client’s needs and include anticipated modifications or accessory needs, as well as the anticipated width of the medical stroller to allow client growth with use of lateral and thigh supports.

- Include significant medical information pertinent to the client’s mobility and how the requested equipment will accommodate these needs, including intellectual, postural, physical, sensory (visual and auditory), and physical status.

- Address trunk and head control, balance, arm and hand function, existence and severity of orthopedic deformities, any recent changes in the client’s physical or functional status, and any expected or potential surgeries that will improve or further limit mobility.

- Include information on the client’s current mobility and seating equipment, how long the client has been in the current equipment, and why it no longer meets the client’s needs.
• Include the client’s height, weight, and a description of where the equipment is to be used.

Seating measurements are required.
• Include information on the accessibility of the client’s residence.
• Include manufacturer’s information, including the description of the specific base, any attached seating system components, and any attached accessories.

2.5.10.2.7 Stroller Ramps—Portable and Threshold
One portable and one threshold ramp for stroller access may be considered for prior authorization when documentation supports medical necessity and includes the following:
• Diagnosis with duration of expected need
• A diagram of the house showing the access points with the ground-to-floor elevation and any obstacles

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

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

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

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

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

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

A special-needs car seat must have a top tether installed. The top tether is essential for proper use of the car seat. The installer is reimbursed for the installation by the manufacturer. The provider must maintain a statement that has been signed and dated by the client’s parent or legal guardian in the client’s medical record that states the following:
• A top tether has been installed in the vehicle in which the client will be transported by a manufacturer-trained vendor.
• Training in the correct use of the car seat has been provided by a manufacturer-trained vendor.
• The client’s parent or guardian has received instruction and has demonstrated the correct use of the car seat to a manufacturer-trained vendor.

To request prior authorization for a special-needs car seat or accessories, all of the following criteria must be met:
• The client must weigh at least 40 pounds or be at least 40 inches in height.
• The supporting documentation must include the following:
  • Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, including the client’s overall health status.
• A description of the client’s postural condition specifically including head and trunk control (or lack of control) and why a booster chair or seatbelt will not meet the client’s needs. The car seat must be able to support the head if head control is poor.

• The expected long term need for the special needs car seat.

• A copy of the manufacturer’s certification for the installer’s training to insert the specified car seat, such as Columbia Medical Manufacturing Corporation for Columbia products.

2.5.11 Nutritional Products

2.5.11.1 Services, Benefits, and Limitations

Medical nutritional products including enteral formulas and food thickener, may be approved for clients who are CCP-eligible, birth through 20 years of age, and have specialized nutritional requirements. Medical nutritional products must be prescribed by a physician and be medically necessary.

Nutritional products may be reimbursed with the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4100</td>
</tr>
<tr>
<td>B4158</td>
</tr>
</tbody>
</table>

Enteral nutrition supplies and equipment may be reimbursed with the following procedure codes and limitations:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4322</td>
<td>4 per month</td>
</tr>
<tr>
<td>A5200</td>
<td>2 per month</td>
</tr>
<tr>
<td>B4034</td>
<td>Up to 31 per month</td>
</tr>
<tr>
<td>B4035</td>
<td>Up to 31 per month</td>
</tr>
<tr>
<td>B4036</td>
<td>Up to 31 per month</td>
</tr>
<tr>
<td>B4081</td>
<td>As needed</td>
</tr>
<tr>
<td>B4082</td>
<td>As needed</td>
</tr>
<tr>
<td>B4083</td>
<td>As needed</td>
</tr>
<tr>
<td>B4087</td>
<td>2 per rolling year</td>
</tr>
<tr>
<td>B4088</td>
<td>2 per rolling year</td>
</tr>
<tr>
<td>B9000</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>B9002</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>B9998*</td>
<td>As needed*</td>
</tr>
<tr>
<td>B9998 with modifier U1</td>
<td>4 per month</td>
</tr>
<tr>
<td>B9998 with modifier U2</td>
<td>2 per rolling year</td>
</tr>
<tr>
<td>B9998 with modifier U3</td>
<td>4 per month</td>
</tr>
<tr>
<td>B9998 with modifier U5</td>
<td>4 per month</td>
</tr>
<tr>
<td>T1999*</td>
<td>As needed*</td>
</tr>
</tbody>
</table>

* Appropriate limitations for miscellaneous procedure codes B9998 and T1999 are determined on a case-by-case basis through prior authorization. Specific items may be requested using procedure code B9998 and the modifiers outlined in the table above.
The purchase of a backpack or carrying case for a portable enteral feeding pump may be a benefit of CCP, using procedure code B9998, if it is medically necessary and prior-authorized.

Clients for whom nutritional products are being requested may benefit from nutritional counseling. Nutritional counseling is a benefit of CCP if it is provided to treat, prevent, or minimize the effects of illness, injury, or other impairment.

Refer to: Subsection 2.7, “Medical Nutrition Counseling Services (CCP)” in this handbook for information about nutritional counseling.

2.5.11.2 Women, Infants, and Children Program (WIC)

Generic nutritional products that have been approved by the United States Department of Agriculture (USDA) for use in the Women, Infants, and Children Program (WIC) may be approved for use by CCP clients.

While CCP does not require that a client access WIC, it is only recommended as another source of services for clients who are 4 years of age and younger, or clients who are pregnant or breast feeding. Nutritional products are not provided to infants who are 11 months of age and younger unless medical necessity is documented.

2.5.11.3 Noncovered Services

CCP will not cover the following:

- Nutritional products that are traditionally used for infant feeding.
- Nutritional products for the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth. The underlying cause of failure to thrive, gain weight, and lack of growth is required.
- Nutritional bars.
- Nutritional products for clients who could be sustained on an age-appropriate diet.

2.5.11.4 Prior Authorization and Documentation Requirements

Prior authorization for nutritional products is not required for a client who meets at least one of the following criteria:

- Client receives all or part of their nutritional intake through a tube.
- Client has a metabolic disorder that has been documented with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2700 2701 2702 2703 2704 2705 2706 2707 2708 2709</td>
</tr>
<tr>
<td>2710 2711 2712 2713 2714 2718 2719 2720 2721 2722</td>
</tr>
<tr>
<td>2723 2724 2725 2726 2727 2728 2729 2730 2731 2732</td>
</tr>
<tr>
<td>2733 2734 2738 2739 27400 27401 27402 27403 27410 27411</td>
</tr>
<tr>
<td>27419 27481 27482 27489 2749 2751 2752 2753 27540 27541</td>
</tr>
<tr>
<td>27542 27549 2755 2758 2759 2760 2761 2762 2763 2764</td>
</tr>
<tr>
<td>27650 27651 27652 2767 2768 2769 27700 27701 27702 27703</td>
</tr>
<tr>
<td>27709 2771 2772 27730 27731 27739 2774 2775 2776 2777</td>
</tr>
<tr>
<td>27781 27782 27783 27784 27785 27786 27787 27789 2779 2782</td>
</tr>
<tr>
<td>2783 2784 2788 27900 27901 27902 27903 27904 27905 27906</td>
</tr>
<tr>
<td>27909 27910 27911 27912 27913 27919 2792 2793 27941 27949</td>
</tr>
<tr>
<td>2798 2799 V1367 V441 V444 V551</td>
</tr>
</tbody>
</table>
Prior authorization is required for nutritional products that are provided through CCP to clients who do not meet the criteria above and for all related supplies and equipment.

A completed CCP Prior Authorization Request Form that prescribes the DME and supplies must be signed and dated by a prescribing physician who was familiar with the client before making the authorization request. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed CCP Prior Authorization Request Form must include the procedure codes and numerical quantities for the services requested. A copy of the completed, signed, and dated CCP Prior Authorization Form must be maintained by the prescribing physician in the client’s medical record at the provider’s place of business.

Requests for prior authorization must include the following documentation:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition that resulted in the requirement for a nutritional product, as well as any other medical diagnoses or conditions, including:
  - The client’s overall health status.
  - Height and weight.
  - Growth history and growth charts.
  - Why the client cannot be maintained on an age-appropriate diet.
  - Other formulas tried and why they did not meet the client’s needs.
- Diagnosis or condition (including the appropriate ICD-9-CM code).
- The goals and timelines on the medical plan of care.
- Total caloric intake prescribed by the physician.
- Acknowledgement that the client has a feeding tube in place.

Related supplies and equipment for clients who require nutritional products may be considered for prior authorization when the criteria for nutritional products are met and medical necessity is included for each item requested.

Prior authorization may be given for up to 12 months. Prior authorization may be recertified with documentation that supports the ongoing medical necessity of the requested nutritional products.

A retrospective review may be performed to ensure that the documentation included in the client’s medical record supports the medical necessity of the requested service.

### 2.5.11.4.1 Nutritional Products

Requests for prior authorization, when required, must include the necessary product information.

Enteral formulas consisting of semi-synthetic intact protein or protein isolates (procedure codes B4150 and B4152) are appropriate for the majority of clients who require enteral nutrition.

Special enteral formula or additives (procedure code B4104) may be considered for prior authorization with supporting documentation submitted by the client’s physician indicating the client’s medical needs for these special enteral formulas. Special enteral formula may be reimbursed with the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4149</td>
</tr>
</tbody>
</table>

Food thickener may be considered for clients with a swallowing disorder.
Prior authorization of nutritional pudding products may be considered for children who have a documented oropharyngeal motor dysfunction and receive greater than 50 percent of their daily caloric intake from a nutritional pudding product.

Requests for electrolyte replacement products, such as Pedialyte or Oralyte, require documentation of medical necessity, including:

- The underlying acute or chronic medical diagnoses or conditions that indicate the need to replace fluid and electrolyte losses.
- The presence of mild to moderate dehydration due to the persistent mild to moderate diarrhea or vomiting.

Electrolyte replacement products are not indicated for clients with:

- Intractable vomiting
- Adynamic ileus
- Intestinal obstruction or perforated bowel
- Anuria, oliguria, or impaired homeostatic mechanism
- Severe, continuing diarrhea, when intended for use as the sole therapy

**Nasogastric, Gastrostomy, or Jejunostomy Feeding Tube**

Feeding tubes require prior authorization. Additional feeding tubes may be prior authorized if the submitted documentation supports medical necessity, such as documentation of an infection at the gastrostomy site, leakage, or occlusion.

**Enteral Feeding Pumps**

The prior authorization of the lease or purchase of enteral feeding pumps may be considered with documentation of medical necessity that indicates that the client meets the following criteria:

- Gravity or syringe feedings are not medically indicated.
- The client requires an administration rate of less than 100 ml. per hr.
- The client requires night-time feedings.
- The client has one of the following medical conditions (this list is not all-inclusive):
  - Reflux or aspiration
  - Severe diarrhea
  - Dumping syndrome
  - Blood glucose fluctuations
  - Circulatory overload

**Enteral Supplies**

Enteral supplies require prior authorization, with the exception of irrigation syringes (procedure code A4322) and percutaneous catheter/tube anchoring devices (procedure code A5200) with the allowable limits.

Additional enteral feeding supply kits beyond the stated benefit limitation may be considered for prior authorization on a case-by-case basis with documentation of medical necessity.

Procedure code B4034 will not be prior authorized for use in place of procedure code A4322 for irrigation syringes if they are not part of a bolus administration kit. Gravity bags and pump nutritional containers are included in the feeding supply kits and will not be prior authorized separately.
Specific items may be considered for prior authorization using miscellaneous procedure code B9998 and modifier U1, U2, U3, or U5.

Requests for a backpack or carrying case or for a portable enteral feeding pump will be considered for prior authorization for clients who meet all of the following medical necessity criteria:

- The client requires enteral feedings that last more than eight continuous hours, or feeding intervals that are greater than the time that the client must be away from home to:
  - Attend school or work.
  - Participate in extensive, physician-ordered outpatient therapies.
  - Attend frequent, multiple medical appointments.
  - The client is ambulatory or uses a wheelchair that will not support the use of a portable pump by other means, such as an intravenous (IV) pole.
  - The portable enteral feeding pump is client-owned.

**2.5.11.5 Managed Care Clients**

Nutritional products that are provided to WIC clients are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client’s managed care organization (MCO).

Nutrition products that are provided to other Medicaid Managed Care Program clients (other than WIC clients) are not carved out and must be submitted to the managed care organization that administers the client’s Medicaid managed care benefits.

**2.5.12 Hospital Beds, Cribs, and Equipment**

**2.5.12.1 Services, Benefits, and Limitations**

The following items may be considered under CCP:

- Pediatric hospital cribs and beds
- Enclosure frame, canopy, or bubble tops
- Positioning pillows or cushions
- Reflux wedges
- Reflux slings

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

The items listed above may be a benefit for clients who are CCP-eligible when documentation submitted clearly shows that the equipment is medically necessary and will correct or ameliorate the client’s disability or physical or mental illness or condition. Hospital beds, cribs, and equipment are a benefit when all the following criteria are met:

- FFP must be available.
- The requested equipment or supplies must be safe for use in the home.

A pediatric hospital bed or pediatric crib is defined as a fully enclosed bed with all of the following features:

- A bed that allows adjustment of the head and foot of the bed.
- A manual pediatric hospital bed (procedure code E0328) or pediatric crib (procedure code E0300) allows manual adjustment to the head and leg elevation.
- A semi-electric or fully electric hospital bed (procedure code E0329) allows manual or electric adjustments to height and electric adjustments to head and leg elevation.

- A headboard
- A footboard
- A mattress
- Side rails of any type (A side rail is defined as a hinged or removable rail, board, or panel.)

Pediatric hospital beds and pediatric cribs that do not have all of these features will not be considered for prior authorization.

A bed that has side rails that extend 24 inches or less above the mattress is considered a pediatric hospital bed (procedure code E0328 or E0329). A pediatric hospital bed may be fixed or variable height. Variable height beds may be adjusted manually or electrically as required for the client’s medical condition.

Procedure codes E0328 and E0329 are restricted to clients who are 20 years of age and younger.

A bed that has side rails that extend more than 24 inches above the mattress is considered a pediatric crib (procedure code E0300).

A pediatric hospital bed or pediatric crib of any width that has all of the features defined above may be considered for prior authorization using only procedure code E0300, E0328, or E0329.

Hospital beds that are not fully enclosed can be considered through Texas Medicaid home health services.

**Note:** Texas Medicaid defines fully enclosed as having 360-degree side enclosures.

The following procedure codes are used when billing for the rental or purchase of pediatric hospital beds, cribs, and equipment:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0190*</td>
</tr>
</tbody>
</table>

*Purchase only

**Note:** Procedure code E1399 may be used for reflux slings only.

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

Procedure code E0316 may be used in conjunction with procedure codes E0300, E0328, or E0329 to request a pediatric fully-enclosed bed with a canopy.

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

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

Procedure code E0190 with modifier UD must be used to bill the purchase of reflux wedges and positional devices (positioning pillows and cushions). This code and modifier will require manual pricing. Procedure code E0190 is limited to once per three years, per client, any provider.

Procedure code K0739 may be reimbursed for the repair of equipment.
2.5.12.2 Prior Authorization and Documentation Requirements

Prior authorization is required for all DME and services provided through CCP, including any accessories, modifications, adjustments, replacements, and repairs to the equipment.

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

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

A determination will be made by HHSC or its designee whether the equipment will be rented, purchased, repaired, or modified based on the client’s needs, duration of use, and age of equipment. All modifications, adjustments, and repairs within the first six months after delivery are considered to be part of the purchase price.

2.5.12.2.1 Hospital Beds and Safety Enclosure

Pediatric hospital beds and pediatric cribs (procedure codes E0300, E0316, E0328, and E0329) may be considered for prior authorization when the documentation submitted clearly shows that the requested bed or crib will correct or ameliorate the client’s condition. The documentation must meet at least one of the following criteria:

- The client’s medical condition requires positioning of the body in ways that are not feasible in an ordinary bed, including, but not limited to, the need for positioning to alleviate pain.
- The head of the bed must be elevated 30 or more degrees most of the time due to, but not limited to, congestive heart failure, chronic pulmonary disease, or problems with aspiration, and alternative measures, such as wedges or pillows, have been attempted but have failed to manage the client’s medical condition.

Note: Texas Medicaid defines a failed measure as having no clinically significant improvement after being introduced.

- The client requires traction equipment that can only be attached to a hospital bed.

A semi-electric or fully electric hospital bed (procedure code E0329) may be considered for prior authorization when the submitted documentation shows that the client has a medical condition that requires frequent changes in body position or might require an immediate change in body position to avert a life-threatening situation.

The safety enclosure frame, canopy, or bubble top may be considered for prior authorization with documentation that the protective canopy top or bubble will provide for the client’s safety. Prior authorization will not be considered when it will be used as a restraint or for the convenience of family or caregivers.
2.5.12.2.2 Positioning Devices

Reflux slings or wedges may be considered for prior authorization for clients who are 11 months of age and younger. These may be used as positioning devices for infants who require the head of the bed or crib to be elevated greater than 30 degrees after feedings when prescribed by a physician as medically necessary and appropriate.

Positioning pillows and cushions may be considered for prior authorization with documentation of medical necessity that indicates the item will provide for or assist in the positioning needs of the client to maintain proper body alignment and skin integrity. Documentation must include what other devices have been used previously and why they proved to be ineffective.

Items used for PT or rehabilitation in the home are provided by the therapist. Requests for authorization for these purposes will not be considered.

2.5.12.2.3 Repair or Replacement

Repairs require replacement of components that are no longer functional. Technician fees are considered to be part of the cost of the repair.

Repairs to client-owned equipment may be considered with documentation of medical necessity.

Providers are responsible for maintaining documentation in the client’s medical record specifying the repairs and supporting medical necessity.

Rental equipment may be considered during the period of repair. Routine maintenance of rented equipment is the provider’s responsibility.

Pediatric hospital cribs and beds, enclosed beds, and safety enclosure frames, canopies, or bubble tops that have been purchased are anticipated to last a minimum of five years.

Prior authorization for replacement may be considered within five years of purchase if one of the following occurs:

- There has been a significant change in the client’s condition such that the current equipment no longer meets the client’s needs.
- The equipment is no longer functional and cannot be repaired or it is not cost effective to repair.

Replacement equipment may also be considered if loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

2.5.13 Phototherapy Devices

2.5.13.1 Services, Benefits, and Limitations

The rental of phototherapy devices (procedure code E0202) for use in the home are a benefit of Texas Medicaid for low-risk infants.

Low-risk infants are 35 or more weeks gestation at birth, without comorbidity, and with a total serum bilirubin (TSB) level within the following ranges:

<table>
<thead>
<tr>
<th>Infant’s Gestation at Birth</th>
<th>TSB for infant 0-24 hours of age*</th>
<th>TSB for infant 25-48 hours of age*</th>
<th>TSB for infant 49-72 hours of age*</th>
<th>TSB for infant older than 72 hours of age*</th>
</tr>
</thead>
<tbody>
<tr>
<td>38 weeks or greater</td>
<td>6–11</td>
<td>12–15</td>
<td>15–18</td>
<td>18–21</td>
</tr>
</tbody>
</table>

* Infant age when TSB level is drawn.

TSB levels are expressed in milligrams per deciliter (mg/dl).
Consideration for the rental of a home phototherapy device includes, but is not limited to, the following primary diagnoses:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>7740</td>
</tr>
</tbody>
</table>

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

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

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

If a client who is receiving PDN services requires phototherapy, instructions in the use of the equipment must be part of the existing PDN authorized hours. SN visits will not be allowed on the same day as PDN services.

In accordance with American Academy of Pediatrics (AAP) guidelines, providers must conduct ongoing assessments for risk of severe hyperbilirubinemia for all infants who receive home phototherapy.

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

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

### 2.5.13.2 Prior Authorization and Documentation Requirements

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

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

For stabilized infants who began phototherapy treatment during their hospitalization and have been discharged from the hospital, prior authorization will be considered for the continuation of phototherapy services in the home. Initial prior authorization may be given for a maximum of seven days of home phototherapy. A new “CCP Prior Authorization Request Form” must be submitted to request more than seven days of home phototherapy.
The following documentation is required to support medical necessity when requesting home phototherapy services:

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

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

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

- TSB level greater than 13 mg/dl and trending downward. TSB levels less than 13 will require medical review to determine medical necessity.
  
  **Note:** According to AAP guidelines, phototherapy may be discontinued when the TSB level falls below 13–14 mg/dl; however, exceptions to the guidelines may be considered. As a result, documentation must include the rationale for not discontinuing phototherapy when the TSB level drops below 13 mg/dl.

- Birth weight and current weight demonstrating weight gain.
  
  **Note:** According to AAP guidelines, breast-fed infants are expected to gain 15-30 grams per day (1/2-1 ounce per day) through the first 2-3 months of life.

2.5.13.2.1 Retroactive Eligibility

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

- The provider is responsible for finding out the effective dates of client eligibility.
- The provider has 95 days from the date on which the client’s Medicaid number becomes available (add date) to obtain prior authorization for services that were already rendered.
2.5.14 Special Needs Car Seats and Travel Restraints

2.5.14.1 Services, Benefits, and Limitations

2.5.14.1.1 Special Needs Car Seats

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

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

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

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

2.5.14.1.2 Travel Safety Restraints

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

2.5.14.2 Prior Authorization and Documentation Requirements

2.5.14.2.1 Special Needs Car Seats

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

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

- A top tether has been installed in the vehicle in which the client will be transported, by a manufacturer-trained vendor.
- Training in the correct use of the car seat has been provided by a manufacturer-trained vendor.
- The client’s parent or legal guardian has received instruction and has demonstrated the correct use of the car seat to a manufacturer-trained vendor.

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

The client’s weight must be at least 40 pounds, or the client’s height must be at least 40 inches.

Supporting documentation must include the following and must be submitted for prior authorization:

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

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

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

2.5.15 Total Parenteral Nutrition (TPN)

2.5.15.1 Services, Benefits, and Limitations

In-home TPN is a benefit of CCP for clients who require short-term or long-term nutritional support. Covered services must be medically necessary and prescribed by the physician.

Parenteral nutrition solution, supplies, and infusion pumps services may be reimbursed with the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Solution Procedure Codes</strong></td>
</tr>
<tr>
<td>B4164</td>
</tr>
<tr>
<td>B4199</td>
</tr>
<tr>
<td><strong>Supply Procedure Codes</strong></td>
</tr>
<tr>
<td>B4220</td>
</tr>
<tr>
<td><strong>Infusion Pump Procedure Codes</strong></td>
</tr>
<tr>
<td>B9004</td>
</tr>
</tbody>
</table>

If the solutions and additives are shipped and not used because of the client’s loss of eligibility, change in treatment, or inpatient hospitalization, then no more than a one-week supply of solutions and additives will be reimbursed. Any days on which the client is an inpatient of a hospital or other medical facility or institution will be excluded from the daily billing. Payment for partial months will be prorated based upon the actual days of administration. The administration of intravenous fluids and electrolytes cannot be billed as in-home TPN.

A backpack or carrying case for a portable infusion pump may be a benefit when it is medically necessary and must be billed using procedure code B9999.

The infusion pump may be rented once a month or purchased once every five years.

2.5.15.2 Prior Authorization and Documentation Requirements

Prior authorization is required for TPN solutions, lipids, supply kits, and infusion pumps that are provided through CCP. Renewal of the prior authorization will be considered on the basis of medical necessity.

TPN solutions, lipids, supply kits, and infusion pumps will be considered for the prior authorization of short-term or long-term nutritional therapy for clients who are CCP-eligible when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client’s disability or physical or mental illness or condition. Documentation must include the following:

- Conditions that result in a loss of function of the gastrointestinal (GI) tract and the inability to obtain adequate nutrition by the enteral route, such as:
  - Infections of the pancreas, intestines, or other body organs that result in a loss of GI function
  - Inflammatory bowel disease
  - Necrotizing enterocolitis
• Malnutrition
• Trauma
• Overwhelming systemic infections
• Serious burns
• Conditions that result in an inability of the bowel to absorb nutrition, such as:
  • Extensive bowel resection
  • Severe, advanced bowel disease. Examples include short bowel syndrome (SBS), chronic intestinal pseudo-obstruction (CIPS), Hirschprungs disease (HD), Crohn’s disease, and ulcerative colitis
• Prematurity
• Leukemias
• Congenital gastrointestinal anomalies
• Acquired immunodeficiency syndrome

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the equipment and supplies requested. The physician must also maintain documentation of medical necessity in the client’s medical record.

Prior authorization requests for TPN must include the following information:
• Medical condition for which TPN is necessary
• Documentation of any trials with oral and enteral feedings
• Percent of daily nutritional needs from TPN
• A copy of the TPN formula or prescription that includes amino acids and lipids and is signed and dated by the physician
• A copy of the most recent laboratory results that includes potassium, calcium, liver function studies, and albumin

Note: Conditions or durations of need that are not listed above may be considered by HHSC or its designee with documentation of medical necessity.

Prior authorization requests for a portable parenteral nutrition infusion pump (procedure code B9004) must also include documentation of medical necessity that demonstrates at least one of the following:
• The client requires continuous feedings.
• Feeding intervals exceed the time that the client must be away from home to:
  • Attend school or work
  • Participate in extensive, physician-ordered outpatient therapies
  • Attend frequent, multiple, medical appointments

Prior authorization for parenteral nutrition infusion pumps are limited to one portable pump (procedure code B9004) or one stationary pump (procedure code B9006) at any one time, unless medical necessity for two infusion pumps is established. Supporting documentation for the additional pump must be included with the prior authorization request.

Prior authorization requests for miscellaneous procedure code B9999 must include the following:
• A detailed description of the requested item or supply
- Documentation that supports the medical necessity of the requested item or supply

Requests for a backpack or carrying case for the portable infusion pump will be considered for prior authorization under miscellaneous code B9999, if the clients meet the medical necessity criteria for the portable pump that are outlined above. The following criteria also apply:

- The client is ambulatory or uses a wheelchair that will not support the use of a portable pump by other means, such as an intravenous (IV) pole.
- The portable enteral feeding pump is client-owned.

The requesting provider may be asked for additional information to clarify or complete a request for TPN services.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the TPN services.

### 2.5.16 Vitamin and Mineral Products

#### 2.5.16.1 Services, Benefits, and Limitations

Vitamin and mineral products prescribed or ordered by a physician to treat various conditions are a benefit of Texas Medicaid through CCP for clients who are 20 years of age and younger.

Vitamin and mineral products must be submitted with procedure code A9152 or A9153, the appropriate modifier, and the corresponding National Drug Code. Units must be based on the quantity dispensed, for up to a 30-day supply.

*Note:* It is acceptable for providers to bill in excess of a 30-day supply when billing for liquid formulations due to variances in container size.

For purposes of billing, one unit is equal to one dose. The total billable units are equal to the total doses requested on the prior authorization.

Providers must dispense the most cost-effective product prescribed in accordance with a prescription from a licensed physician. Organic products will not be reimbursed unless medical documentation is provided to substantiate the need for that formulation.

The following vitamin and mineral products may be a benefit when submitted with the corresponding procedure code and state-identified modifier:

<table>
<thead>
<tr>
<th>Vitamin or Mineral</th>
<th>Procedure Code</th>
<th>State-Identified Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beta-carotene</td>
<td>A9152</td>
<td>U1</td>
</tr>
<tr>
<td>Vitamin A (retinol)</td>
<td>A9152</td>
<td>U1</td>
</tr>
<tr>
<td>Biotin</td>
<td>A9152</td>
<td>U2</td>
</tr>
<tr>
<td>Boric acid</td>
<td>A9152</td>
<td>U3</td>
</tr>
<tr>
<td>Copper</td>
<td>A9152</td>
<td>U3</td>
</tr>
<tr>
<td>Iodine</td>
<td>A9152</td>
<td>U3</td>
</tr>
<tr>
<td>Phosphorus</td>
<td>A9152</td>
<td>U3</td>
</tr>
<tr>
<td>Zinc</td>
<td>A9152</td>
<td>U3</td>
</tr>
<tr>
<td>Calcium</td>
<td>A9152</td>
<td>U4</td>
</tr>
<tr>
<td>Chloride</td>
<td>A9152</td>
<td>U5</td>
</tr>
<tr>
<td>Iron</td>
<td>A9152</td>
<td>U6</td>
</tr>
<tr>
<td>Magnesium</td>
<td>A9152</td>
<td>U7</td>
</tr>
<tr>
<td>Vitamin B1 (thiamin)</td>
<td>A9152</td>
<td>U8</td>
</tr>
<tr>
<td>Vitamin B2 (riboflavin)</td>
<td>A9152</td>
<td>U8</td>
</tr>
</tbody>
</table>
Claims for multivitamins with any combination of additives must be submitted with modifier U2.

Vitamin and mineral products may be indicated for, but are not limited to, treatment of the following conditions:

<table>
<thead>
<tr>
<th>Vitamin or Mineral</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beta-carotene</td>
<td>Vitamin A deficiency</td>
</tr>
<tr>
<td></td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td></td>
<td>Disorders of porphyrin metabolism</td>
</tr>
<tr>
<td></td>
<td>Intestinal malabsorption</td>
</tr>
<tr>
<td></td>
<td>Biotin deficiency</td>
</tr>
<tr>
<td></td>
<td>Biotinidase deficiency</td>
</tr>
<tr>
<td></td>
<td>Carnitine deficiency</td>
</tr>
<tr>
<td>Biotin</td>
<td>Recalcitrant vulva vaginitis</td>
</tr>
<tr>
<td>Calcium</td>
<td>Calcium deficiency</td>
</tr>
<tr>
<td></td>
<td>Disorders of calcium metabolism</td>
</tr>
<tr>
<td></td>
<td>Chronic renal disease</td>
</tr>
<tr>
<td></td>
<td>Pituitary dwarfism, isolated growth hormone deficiency</td>
</tr>
<tr>
<td></td>
<td>Hypocalcemia and hypomagnesaemia of the newborn</td>
</tr>
<tr>
<td></td>
<td>Intestinal disaccharidase deficiencies and disaccharide malabsorption</td>
</tr>
<tr>
<td></td>
<td>Allergic gastroenteritis and colitis</td>
</tr>
<tr>
<td></td>
<td>Hypocalcemia due to use of Depo-Provera contraceptive injection</td>
</tr>
<tr>
<td>Chloride</td>
<td>Hypochloremia</td>
</tr>
<tr>
<td></td>
<td>Hypercapnia with mixed acid-base disorder</td>
</tr>
<tr>
<td></td>
<td>Bronchopulmonary dysplasia</td>
</tr>
<tr>
<td>Copper</td>
<td>Disorders of copper metabolism</td>
</tr>
<tr>
<td>Vitamin or Mineral</td>
<td>Condition</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Iodine</td>
<td>Iodine deficiency</td>
</tr>
<tr>
<td></td>
<td>Simple and unspecified goiter and nontoxic nodular goiter</td>
</tr>
<tr>
<td>Iron</td>
<td>Disorders of iron metabolism</td>
</tr>
<tr>
<td></td>
<td>Iron deficiency anemia</td>
</tr>
<tr>
<td></td>
<td>Sideroachrestic anemia</td>
</tr>
<tr>
<td>Magnesium</td>
<td>Magnesium deficiency</td>
</tr>
<tr>
<td></td>
<td>Hypoparathyroidism</td>
</tr>
<tr>
<td>Phosphorus</td>
<td>Disorders of phosphorus metabolism</td>
</tr>
<tr>
<td>Vitamin A (retinol)</td>
<td>Vitamin A deficiency</td>
</tr>
<tr>
<td></td>
<td>Intestinal malabsorption</td>
</tr>
<tr>
<td></td>
<td>Disorders of the biliary tract</td>
</tr>
<tr>
<td></td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td>Vitamin B1 (thiamin)</td>
<td>Vitamin B1 deficiency</td>
</tr>
<tr>
<td></td>
<td>Disturbances of branched-chain amino-acid metabolism (e.g., maple syrup urine disease)</td>
</tr>
<tr>
<td></td>
<td>Disorders of mitochondrial metabolism</td>
</tr>
<tr>
<td></td>
<td>Wernicke-Korsakoff syndrome</td>
</tr>
<tr>
<td>Vitamin B2 (riboflavin)</td>
<td>Vitamin B2 deficiency</td>
</tr>
<tr>
<td></td>
<td>Disorders of fatty acid oxidation</td>
</tr>
<tr>
<td></td>
<td>Riboflavin deficiency, ariboflavinosis</td>
</tr>
<tr>
<td></td>
<td>Disorders of mitochondrial metabolism</td>
</tr>
<tr>
<td>Vitamin B3 (niacin)</td>
<td>Vitamin B3 deficiency</td>
</tr>
<tr>
<td></td>
<td>Disorders of lipid metabolism, (e.g., pure hypercholesterolemia)</td>
</tr>
<tr>
<td>Vitamin B5 (pantothenic acid)</td>
<td>Vitamin B5 deficiency</td>
</tr>
<tr>
<td>Vitamin B6 (pyridoxine, pyridoxal 5-phosphate)</td>
<td>Vitamin B6 deficiency</td>
</tr>
<tr>
<td></td>
<td>Sideroblastic anemia</td>
</tr>
<tr>
<td>Vitamin B9 (folic acid)</td>
<td>Vitamin B9 deficiency</td>
</tr>
<tr>
<td></td>
<td>Folate-deficiency anemia</td>
</tr>
<tr>
<td></td>
<td>Combined B12 and folate-deficiency anemia</td>
</tr>
<tr>
<td></td>
<td>Disorders of mitochondrial metabolism</td>
</tr>
<tr>
<td></td>
<td>Sickle-cell disease</td>
</tr>
<tr>
<td></td>
<td>Pernicious anemia</td>
</tr>
<tr>
<td>Vitamin B12 (cyanocobalamin)</td>
<td>Vitamin B12 deficiency</td>
</tr>
<tr>
<td></td>
<td>Disturbances of sulphur-bearing amino-acid metabolism (e.g., homocystinuria and disturbances of metabolism of methionine)</td>
</tr>
<tr>
<td></td>
<td>Pernicious anemia</td>
</tr>
<tr>
<td></td>
<td>Combined B12 and folate-deficiency anemia</td>
</tr>
<tr>
<td>Vitamin C (ascorbic acid)</td>
<td>Vitamin C deficiency</td>
</tr>
<tr>
<td></td>
<td>Anemia due to disorders of glutathione metabolism</td>
</tr>
<tr>
<td></td>
<td>Disorders of mitochondrial metabolism</td>
</tr>
<tr>
<td>Vitamin or Mineral</td>
<td>Condition</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Vitamin D (ergocalciferol)</td>
<td>Vitamin D deficiency</td>
</tr>
<tr>
<td></td>
<td>Galactosemia</td>
</tr>
<tr>
<td></td>
<td>Glycogenosis</td>
</tr>
<tr>
<td></td>
<td>Disorders of magnesium metabolism</td>
</tr>
<tr>
<td></td>
<td>Intestinal malabsorption</td>
</tr>
<tr>
<td></td>
<td>Chronic renal disease</td>
</tr>
<tr>
<td></td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td></td>
<td>Disorders of phosphorus metabolism</td>
</tr>
<tr>
<td></td>
<td>Hypocalcemia</td>
</tr>
<tr>
<td></td>
<td>Disorders of the biliary tract</td>
</tr>
<tr>
<td></td>
<td>Hypoparathyroidism</td>
</tr>
<tr>
<td></td>
<td>Intestinal disaccharidase deficiencies and disaccharide malabsorption</td>
</tr>
<tr>
<td></td>
<td>Allergic gastroenteritis and colitis</td>
</tr>
<tr>
<td>Vitamin E (tocopherols)</td>
<td>Vitamin E deficiency</td>
</tr>
<tr>
<td></td>
<td>Inflammatory bowel disease (e.g., Crohn’s, granulomatous enteritis, and ulcerative colitis)</td>
</tr>
<tr>
<td></td>
<td>Disorders of mitochondrial metabolism</td>
</tr>
<tr>
<td></td>
<td>Chronic liver disease</td>
</tr>
<tr>
<td></td>
<td>Intestinal malabsorption</td>
</tr>
<tr>
<td></td>
<td>Disorders of the biliary tract</td>
</tr>
<tr>
<td></td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td>Vitamin K (phytonadione)</td>
<td>Vitamin K deficiency</td>
</tr>
<tr>
<td></td>
<td>Congenital deficiency of other clotting factors</td>
</tr>
<tr>
<td></td>
<td>Hypoprothrombinemia of the newborn</td>
</tr>
<tr>
<td></td>
<td>Hemorrhagic disease of the newborn</td>
</tr>
<tr>
<td></td>
<td>Intestinal malabsorption</td>
</tr>
<tr>
<td></td>
<td>Acquired coagulation factor deficiency</td>
</tr>
<tr>
<td></td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td></td>
<td>Disorders of the biliary tract</td>
</tr>
<tr>
<td></td>
<td>Chronic liver disease</td>
</tr>
<tr>
<td>Zinc</td>
<td>Zinc deficiency</td>
</tr>
<tr>
<td></td>
<td>Wilson’s disease</td>
</tr>
<tr>
<td></td>
<td>Acrodermatitis enteropathica</td>
</tr>
<tr>
<td>Multi-minerals</td>
<td>Other and unspecified protein-calorie malnutrition</td>
</tr>
<tr>
<td>Multi-vitamins</td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td></td>
<td>Other and unspecified protein-calorie malnutrition</td>
</tr>
<tr>
<td>Trace elements</td>
<td>Mineral deficiency</td>
</tr>
</tbody>
</table>
2.5.16.2 Prior Authorization and Documentation Requirements

Prior authorization for vitamin and mineral products must be requested using the CCP Prior Authorization Request Form. Requests for prior authorizations must be submitted and approved before the date of dispensing the vitamin or mineral products. Prior authorization requests for vitamin and mineral products that are initiated before the date of the physician’s order will not be approved.

The following documentation must be submitted with the prior authorization request:

- A physician’s prescription with the name of the vitamin or mineral product, dosage, frequency, duration, and route of administration
- The MSRP or average wholesale price (AWP), whichever is applicable, or the provider’s documented invoice price
- The calculated price per dose
- Documentation that supports the medical necessity of the requested vitamin or mineral

The following sample tables, taken from the CCP Prior Authorization Request Form, are examples of the information that is required to submit a request for vitamin and mineral products:

- Example 1: Vitamin D

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Brief Description of Requested Services</th>
<th>Retail Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9152 UA</td>
<td>Vitamin D (ergocalciferol) 10 ml bottle (8000 units/ml)</td>
<td>$40.00/bottle</td>
</tr>
<tr>
<td></td>
<td>Dose: 400 units (0.05 ml)</td>
<td>$0.20/dose</td>
</tr>
<tr>
<td></td>
<td>Route: PO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frequency: QD</td>
<td></td>
</tr>
</tbody>
</table>

Note: HCPCS codes and descriptions must be provided.

- Example 2: Multivitamin Tablets

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Brief Description of Requested Services</th>
<th>Retail Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9153 U2</td>
<td>Centrum Kids (80 tablets/bottle)</td>
<td>$8.99/bottle</td>
</tr>
<tr>
<td></td>
<td>Dose: 1 tablet</td>
<td>$0.11/dose</td>
</tr>
<tr>
<td></td>
<td>Route: PO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frequency: QD</td>
<td></td>
</tr>
</tbody>
</table>

Note: HCPCS codes and descriptions must be provided.

Prior authorization requests for products, conditions, or quantities other than those described in the “Benefits” section of this handbook will be considered on a case-by-case basis after review by the medical director. Providers must submit documentation that the prescribed products are for a medically accepted indication. Documentation must include one of the following:

- FDA approval
- The use is supported by one or more citations that are included or approved for inclusion in the following compendia:
  - The American Hospital Formulary Service Drug Information
  - The United States Pharmacopoeia-Drug Information (or its successor publications)
  - The DRUGDEX Information System
  - Two articles from major medical peer-reviewed literature that demonstrate validated, untested data for the use of the agent in a specific medical condition that is safe and effective
Prior authorization of vitamin and mineral products may be granted for up to six months, and for a quantity up to a 30-day supply.

**Note:** Quantities in excess of these limitations may be considered when requesting liquid formulations due to variances in container size.

Requests for additional vitamin and mineral products must be submitted before the current authorized period expires, but no more than 30 days before the expiration.

### 2.5.17 Claims Information

Claims for DME must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper 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.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, Claims Filing (Vol. 1, General Information) for instructions on completing paper claims.

### 2.5.18 Reimbursement

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

Providers may be reimbursed for DME either by the lesser of the provider’s billed charges or the published fee determined by HHSC or through manual pricing. If manual pricing is used, the provider must request prior authorization and submit documentation of either of the following:

- The MSRP or AWP, whichever is applicable.
- The provider’s documented invoice cost.

Manually priced items are reimbursed as follows as is appropriate:

- MSRP less 18 percent or AWP less 10.5 percent, whichever is applicable.
- The provider’s documented invoice cost.

### 2.6 Early Childhood Intervention (ECI) Services

The Texas ECI Program is available statewide to all children who have been determined to be eligible for ECI services by ECI Program providers. To be eligible for ECI services, children must be 35 months of age and younger (i.e., before their third birthday) and have disabilities or developmental delays as defined by ECI criteria. Texas Medicaid covers the ECI claims for children who are Medicaid clients.

All health-care professionals are required by federal and state regulations to refer children who are 35 months of age and younger (i.e., before their third birthday) to the Texas ECI Program as soon as possible, but no longer than 7 days after identifying a disability or suspected delay in development. Referrals can be based on professional judgment or a family’s concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

To refer families for services, providers can call their local ECI program, or they can call the Department of Assistive and Rehabilitative Services (DARS) Inquiry Line at 1-800-628-5115. For additional ECI information, providers can visit the DARS website at www.dars.state.tx.us/ecis. Persons who are hearing-impaired can call the TDD/TTY line at 1-866-581-9328.
2.6.1 Enrollment

DARS contracts with local ECI providers to take referrals, determine clients’ eligibility for the Texas ECI Program, and provide services to ECI-eligible children and their families. ECI providers must be contracted with the Texas ECI Program and must comply with all of the applicable federal and state laws and regulations that govern the Texas ECI Program.

ECI providers are eligible to enroll as Texas Medicaid ECI providers to render services to eligible Medicaid clients. After providers meet the criteria of the Texas ECI Program, they must complete a Medicaid application.

To participate in Texas Medicaid, an ECI provider must be certified by the Texas ECI Program and must submit a copy of the current contract award from the Texas ECI Program.

Refer to: Subsection 1.1, “Provider Enrollment” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information) for more information about the procedures for enrolling as a Medicaid provider.

2.6.2 Services, Benefits, Limitations, and Prior Authorization

ECI services are usually provided in the client’s natural environments, which are defined as settings that individual families identify as natural or normal for their family, including the home, neighborhood, and community settings in which children without disabilities participate. ECI services may be provided in the following places of service (POS): office/facility (POS 1), home (POS 2), and other locations (POS 9).

The Texas ECI Program uses evaluations and assessments to determine eligibility. Clients are eligible for ECI if they are 35 months of age and younger and have a developmental delay, a medically diagnosed condition that has a high probability of resulting in developmental delay, or an auditory or visual impairment as defined by the Texas Education Agency.

Under the Texas ECI Program, families and professionals work together to develop an Individualized Family Service Plan (IFSP) which is based on the unique needs of the client and the client’s family. The IFSP serves as the authorization for the services and documents the medical necessity for the services.

ECI services must be provided as stated in 40 TAC, Part 2, Chapter 108.

Refer to: Texas Administrative Code, Title 40 (40 TAC), Part 2, Chapter 108, Subchapter H.

2.6.2.1 Therapy

Providers may submit claims for therapy services that are included in the client’s IFSP.

A client may receive a combination of PT, OT, ST, or specialized skills training (SST) in the home or community setting when the IFSP indicates necessity for two services to be provided at the same time and the parent(s) have agreed on the two services being provided at the same time.

PT, OT, and ST equipment and supplies used during therapy visits are included in the therapy visit and are not reimbursed separately.

2.6.2.1.1 Occupational Therapy (OT)

OT procedure codes must be submitted with modifier GO.

The following procedure codes must be submitted in 15-minute increments:

<table>
<thead>
<tr>
<th>OT Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97032 97033 97034 97035 97036 97110 97112 97113 97116 97124</td>
</tr>
<tr>
<td>97140 97530 97535 97542 97750 97760 97761 97762</td>
</tr>
</tbody>
</table>
The following procedure codes are limited to once per date of service, for each therapy type (PT and OT):

### OT Procedure Codes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>97012</td>
<td>97014</td>
<td>97016</td>
<td>97018</td>
<td>97022</td>
<td>97024</td>
<td>97026</td>
<td>97028</td>
<td>97150</td>
</tr>
</tbody>
</table>

OT includes services that address the functional needs of a client that are related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the client’s functional ability to perform tasks in the home and community settings.

- All services must be delivered according to §454.213 of the Texas Occupations Code.
- Occupational therapist services must be identified on the IFSP and prescribed by a physician.
- Occupational therapist services may be performed in an individual or group setting.
- Occupational therapist services may be provided in an outpatient, home, or other natural environment setting.

Occupational therapist services are provided by an ECI provider. The ECI provider ensures that occupational therapist services are performed by one of the following:

- A licensed occupational therapist who meets the requirements of 42 CFR §440.110(b).
- A certified occupational therapist assistant (COTA) when the assistant is acting under the direction of a licensed occupational therapist in accordance with 42 CFR §440.110 and all other applicable state and federal laws.

### 2.6.2.1.2 Physical Therapy (PT)

PT procedure codes must be submitted with modifier GP.

The following PT procedure codes may be reimbursed for therapy services and must be submitted in 15-minute increments:

### PT Procedure Codes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>97032</td>
<td>97033</td>
<td>97034</td>
<td>97035</td>
<td>97036</td>
<td>97110</td>
<td>97112</td>
<td>97113</td>
<td>97116</td>
</tr>
<tr>
<td>97140</td>
<td>97530</td>
<td>97535</td>
<td>97542</td>
<td>97750</td>
<td>97760</td>
<td>97761</td>
<td>97762</td>
<td></td>
</tr>
</tbody>
</table>

The following procedure codes are limited to once per date of service, for each therapy type (PT and OT):

### PT Procedure Codes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>97012</td>
<td>97014</td>
<td>97016</td>
<td>97018</td>
<td>97022</td>
<td>97024</td>
<td>97026</td>
<td>97028</td>
<td>97150</td>
</tr>
</tbody>
</table>

PT includes services that address the promotion of sensory and motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation.

- All services must be delivered according to 22 TAC Part 16, Chapter 322, §322.1(a)(2)(A).
- Physical therapist services must be identified on the IFSP and prescribed by a physician.
- Physical therapist services may be performed in an individual or group setting.
- Physical therapist services may be provided in an outpatient, home, or other natural environment setting.
Physical therapist services are provided by an ECI provider. The ECI provider ensures that physical therapist services are performed by one of the following:

- A licensed physical therapist who meets the requirements of 42 CFR §440.110(a).
- A licensed PT assistant (LPTA) when the assistant is acting under the direction of a licensed physical therapist in accordance with 42 CFR §440.110 and all other applicable state and federal laws.

### 2.6.2.1.3 Speech Therapy (ST)

ST procedure codes must be submitted with modifier GN.

The following ST procedure codes may be reimbursed for therapy services and must be submitted in 15-minute increments:

<table>
<thead>
<tr>
<th>ST Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92507</td>
</tr>
<tr>
<td>92508</td>
</tr>
<tr>
<td>92526</td>
</tr>
</tbody>
</table>

Speech and language therapy includes services designed to promote rehabilitation and remediation of delays or disabilities in language-related symbolic behaviors, communication, language, speech, emergent literacy, or feeding and swallowing behavior.

- All services must be delivered according to §401.001(6) of the Texas Occupations Code.
- ST services must be identified on the IFSP.
- ST services may be performed on an individual or group setting.
- ST services may be provided in an outpatient setting, home, or other natural environment setting.

ST services are provided by an ECI provider. The ECI provider ensures that ST services are performed by one of the following:

- A licensed SLP who meets the requirements of 42 CFR §440.110(c) and all other applicable state and federal law.
- A licensed assistant in speech language pathology when the assistant is acting under the direction of a licensed SLP in accordance with 42 CFR §440.110.
- A licensed intern when the intern is acting under the direction of a licensed SLP in accordance with 42 CFR §440.110 and all other applicable state and federal law.

### 2.6.2.2 Specialized Skills Training (SST)

SST is a rehabilitative service that promotes age-appropriate development by providing skills training to correct deficits and teach compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions.

- SST services must be provided as stated in 40 TAC, Part 2, Chapter 108, Subchapter E. Documentation of each SST visit must comply with 40 TAC, Part 2, Chapter 108, Subchapter E, §108.501.
- SST services must be identified on the IFSP and have been recommended by a licensed practitioner of the healing arts (as defined in 40 TAC, Part 2, Chapter 108, Subchapter A, §108.103).
- SST services may be performed in an individual or group setting.

Providers must submit procedure code T1027 for SST services, which are billed in 15-minute increments. Providers must submit procedure code T1027 when services are performed in a group setting or T1027 with modifier U1 when performed in an individual setting.

SST services are provided by an ECI provider. The ECI provider ensures that SST services are provided by an early intervention specialist who meets the criteria established in 40 TAC Part 2, Chapter 108, Subchapter C, §108.313.
2.6.2.3 Targeted Case Management (TCM)

Targeted Case Management (TCM) services are provided to help eligible clients gain access to needed medical, social, educational, developmental, and other appropriate services.

Providers may perform and submit claims for TCM services after the client’s ECI eligibility has been established. The IFSP does not have to be completed before providers may perform TCM services and submit claims to Texas Medicaid.

DARS provides additional guidance to ECI contractors about requirements for including ongoing case management services on the IFSP.

Providers must use procedure code T1017 when billing for TCM services, which are billed in 15-minute increments.

TCM services may be delivered face-to-face or by telephone. Providers must use procedure code T1017 for telephone interaction and T1017 with modifier U1 for face-to-face interaction. The POS is determined by the service coordinator’s location at the time the service is rendered.

Claims may be submitted to Texas Medicaid when the interaction is with the client or the client’s parent(s) (as defined in 10 United States Code (U.S.C.) §1401) or other routine caregiver(s), or occurs in the presence of the client or the client’s parent(s) or other routine caregiver.

Providers may contact other individuals to help eligible clients gain access to needed medical, social, educational, developmental, and other appropriate services, to help identify the eligible client’s needs, to assist the eligible client in obtaining services and to receive useful feedback and alert the service coordinator to changes in the eligible client’s needs. These contacts must be documented in the client’s record, but claims may not be submitted to Texas Medicaid for reimbursement unless the contacts occur in the presence of the client and the client’s parent(s) or other routine caregiver.

TCM must be provided as stated in 40 TAC, Part 2, Chapter 108, Subchapter D.

All documentation must be retained in the client’s record and available upon request. The documentation must be in compliance with 40 TAC, Part 2, Chapter 108, Subchapter D, §108.415.

TCM services are provided by an ECI provider. The ECI provider ensures that TCM services are provided by a service coordinator who meets the criteria established in 40 TAC Part 2, Chapter 108, Subchapter C, §108.315.

2.6.3 Documentation Requirements

All ECI services require documentation to support the medical necessity of the services rendered. ECI services are subject to retrospective review and recoupment if documentation does not support the service that was submitted.

2.6.4 Claims Filing and Reimbursement

2.6.4.1 Claims Information

Claims for ECI therapy, SST, and TCM services that have been rendered by an ECI provider must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers can purchase CMS-1500 paper claim forms from the vendor of their choice; TMHP does not supply the forms. When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills or itemized statements are not accepted as claim supplements.

Claims for ECI services must include the ECI provider identifier and EC1 benefit code.

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

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information) to find the instructions for completing paper claims.

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.

### 2.6.4.1.1 Billing Units Based on 15 Minutes

All claims for reimbursement are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded to the nearest quarter hour.

The following table shows the time intervals for 1 through 8 units:

<table>
<thead>
<tr>
<th>Units</th>
<th>Number of Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 units</td>
<td>0 minutes through 7 minutes</td>
</tr>
<tr>
<td>1 unit</td>
<td>8 minutes through 22 minutes</td>
</tr>
<tr>
<td>2 units</td>
<td>23 minutes through 37 minutes</td>
</tr>
<tr>
<td>3 units</td>
<td>38 minutes through 52 minutes</td>
</tr>
<tr>
<td>4 units</td>
<td>53 minutes through 67 minutes</td>
</tr>
<tr>
<td>5 units</td>
<td>68 minutes through 82 minutes</td>
</tr>
<tr>
<td>6 units</td>
<td>83 minutes through 97 minutes</td>
</tr>
<tr>
<td>7 units</td>
<td>98 minutes through 112 minutes</td>
</tr>
<tr>
<td>8 units</td>
<td>113 minutes through 127 minutes</td>
</tr>
</tbody>
</table>

### 2.6.4.1.2 Managed Care Clients

ECI case management and specialized skills training are carved-out of Medicaid managed care and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid managed care clients but are administered by TMHP and not the client’s MCO.

ECI therapies (PT/OT/ST) are not carved out and must be submitted to the managed care organization (MCO) that administers the client’s managed care benefits.

### 2.6.4.2 Reimbursement

ECI therapy, SST, and TCM services are reimbursed according to a maximum allowable fee established by HHSC. See the applicable fee schedule on the TMHP website at www.tmhp.com.

- ECI therapy services are reimbursed in accordance with 1 TAC §355.8441.
- SST services are reimbursed in accordance with 1 TAC §355.8422.
- TCM services are reimbursed in accordance with 1 TAC §355.8421.

### 2.7 Medical Nutrition Counseling Services (CCP)

#### 2.7.1 Enrollment

Independently practicing licensed dietitians may enroll in Texas Medicaid to provide services to CCP-eligible clients. Dieticians who provide nutrition assessments and counseling must be currently licensed by the Texas State Board of Examiners of Dietitians in accordance with the Licensed Dietitians Act, Chapter 701, Texas Occupations Code.
Refer to: Subsection 2.1.2, "Enrollment" in this handbook for more information about CCP enrollment procedures.

2.7.2 Services, Benefits, and Limitations

Medical nutrition therapy (assessment, re-assessment, and intervention) and medical nutrition counseling may be beneficial for treating, preventing, or minimizing the effects of illness, injuries, or other impairments. A case manager, school counselor, or school nurse may refer a client for medical nutrition counseling services.

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

- The client is 20 years of age or younger
- The client is eligible for CCP
- The services are prescribed by a physician
- The services are performed by a Medicaid-enrolled licensed dietitian
- Clinical documentation supports medical necessity and medical appropriateness
- FFP is available

Medical nutrition therapy and nutrition counseling may be considered beneficial for disease states for which dietary adjustment has a therapeutic role. Such disease states include, but are not limited to, the following conditions:

- Abnormal weight gain
- Cardiovascular disease
- Diabetes or alterations in blood glucose
- Eating disorders
- Gastrointestinal disorders
- Gastrostomy or other artificial opening of gastrointestinal tract
- Hypertension
- Inherited metabolic disorders
- Kidney disease
- Lack of normal weight gain
- Multiple food allergies
- Nutritional deficiencies

Nutrition intervention for the following conditions is considered experimental and investigational and is not a benefit:

- Attention-deficit hyperactivity disorder
- Chemical sensitivities
- Chronic fatigue syndrome
- Idiopathic environmental intolerance

Medical nutrition counseling services for the diagnosis of obesity without a comorbid condition is not a benefit.
Medical nutrition therapy (procedure code 97802) is a more comprehensive service than medical nutrition counseling and is provided to individual clients for assessment and intervention. Procedure code 97802 is limited to one session per day and four units per rolling year.

Medical nutrition therapy (procedure code 97803) is provided to individual clients for a reassessment and intervention, after the initial assessment and intervention. Procedure code 97803 may be used for direct therapy sessions with clients. These sessions are limited to 1 session per day and 12 units per rolling year.

Nutrition assessments and re-assessments are in-depth evaluations of both objective and subjective data related to an individual’s food and nutrient intake, lifestyle, and medical history. Nutrition assessments and re-assessments are performed as part of medical nutrition therapy. Nutrition assessments and re-assessments may be required as a result of a medical diagnosis and may be performed in conjunction with other therapies for treatment or as a goal to help clients make and maintain dietary changes. Documentation must include the following:

- Objective and subjective data obtained
- Height, weight, body mass index (BMI), and correlating percentiles on the growth curves
- Estimated caloric needs
- Nutritional diagnosis
- Intervention and plan
- Evaluation

Medical nutrition counseling (procedure code S9470) is provided to individual clients after an initial assessment and is less comprehensive than medical nutrition therapy. Nutritional counseling may be used to discuss the plan of care or intervention and to determine whether modifications are needed. Procedure code S9470 is limited to one visit per day and four visits per rolling year.

Medical nutrition group therapy (procedure code 97804) is not a benefit in the home setting, and does not include an individual nutrition assessment. Medical nutrition group therapy is limited to eight units per rolling year.

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

- Acquired acanthosis nigricans
- Diabetes
- Dysmetabolic syndrome X
- Eating disorder
- Hyperlipidemia
- Other specified hypoglycemia
- Pure hypercholesterolemia
- Pure hyperglyceridemia
Medical nutrition group therapy sessions must last at least 30 minutes, have a minimum of two clients and a maximum of ten clients, and must include the following:

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

- A question-and-answer period.

Client participation in medical nutrition group therapy is optional. Providers must obtain an informed consent from a client’s parent or guardian before rendering services. The medical documentation maintained in a client’s medical record must include the following:

- Physician prescription
- Referral, if applicable
- Location where the services were provided
- Services that were provided during medical nutrition group therapy
- Goals or objectives for the group therapy
- Client participation
- Beginning and ending time of the group therapy session

In the following table, the procedure codes in Column A will be denied as part of another service if they are submitted by any provider for the same date of service as the corresponding procedure codes in Column B.

<table>
<thead>
<tr>
<th>Column A: Procedure Codes Denied When Submitted With…</th>
<th>Column B: Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9470</td>
<td>97802, 97803, or 97804</td>
</tr>
</tbody>
</table>

Claims for medical nutrition therapy and counseling services should be submitted as follows:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Time Unit</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802 Initial assessment</td>
<td>15 minutes</td>
<td>4 units per rolling year</td>
</tr>
<tr>
<td>97803 Reassessment</td>
<td>15 minutes</td>
<td>12 units per rolling year</td>
</tr>
<tr>
<td>97804 Group</td>
<td>30 minutes</td>
<td>8 units per rolling year</td>
</tr>
<tr>
<td>S9470 Dietitian visit</td>
<td>Per visit</td>
<td>1 visit per day/ 4 visits per rolling year</td>
</tr>
</tbody>
</table>

2.7.3 Prior Authorization and Documentation Requirements

Prior authorization is required for services that exceed the limitations for medical nutrition therapy (assessment, re-assessment, and intervention), medical nutrition group therapy, and nutrition counseling visits.

Prior authorization is also required for consideration of other health conditions that are not addressed.
The following documentation must be submitted to the CCP Prior Authorization Unit for prior authorization:

- Completed CCP Prior Authorization Request Form
- Treatment plan
- Diagnosis of a condition for which there is medical necessity for the service
- Obstacles for not meeting goals
- Interventions planned to meet goals

The prescribing physician and provider must maintain documentation of medical necessity, including the completed CCP Prior Authorization Request Form, in a client’s medical record. The physician must maintain the original signed copy of the CCP Prior Authorization Request Form. The completed CCP Prior Authorization Request Form is valid for a period of up to six months from the date of the physician’s signature.

### 2.7.4 Claims Information

Providers must submit services provided by licensed dietitians in an approved electronic claims format or on a CMS-1500 paper claim form from the vendor of their choice. TMHP does not supply the forms. Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 paper claim form or its equivalent.

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

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

Refer to: Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, Claims Filing (Vol. 1, General Information) for instructions on completing paper claims.

Refer to: Form CH.27, “Medical Nutrition Counseling (CCP Only)” in this handbook for a claim form example.

### 2.7.5 Reimbursement

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

### 2.8 Orthotic and Prosthetic Services (CCP)

#### 2.8.1 Enrollment

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

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

Refer to: Subsection 2.1.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.

#### 2.8.2 Orthotics Services

**2.8.2.1 Services, Benefits, and Limitations**

Orthoses, including orthopedic shoes, wedges, and lifts, are a benefit of Texas Medicaid when provided by a licensed orthotist or a licensed prosthetist/orthotist through CCP for clients who are birth through 20 years of age.
The following orthoses and related services may be reimbursed when medical necessity criteria are met:

- Spinal orthoses and additions to spinal orthoses, including those for scoliosis
- Lower-limb orthoses and additions to lower-limb orthoses, including fracture orthoses
- Foot orthoses, including inserts, orthopedic shoes, surgical boots, heel lifts, and wedges
- Upper-limb orthoses and additions to upper-limb orthoses, including fracture orthoses
- Other orthopedic devices, including protective helmets and dynamic splints
- Repairs, replacements, and modifications
- Orthotic device training

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

**Refer to:** Subsection 2.11, “Therapy Services (CCP)” in this handbook for more information on physical and occupational therapy services.

As defined by the Texas State Board of Orthotics and Prosthetics the following definitions are used by Texas Medicaid:

- An orthosis is defined as: A custom-fabricated or custom-fitted medical device designed to provide for the support, alignment, prevention or correction of neuromuscular or musculoskeletal disease, injury, or deformity. The term does not include a fabric or elastic support, corset, arch support, low-temperature plastic splint, a truss, elastic hose, cane, crutch, soft cervical collar, orthosis for diagnostic or evaluation purposes, dental appliance, or other similar device carried in stock and sold by a drugstore, department store or corset shop.

- A brace is defined as: An orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body, and that allows for motion of that part. It must be a rigid or semirigid device used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a diseased or injured body part.

To be considered for reimbursement, orthoses must be dispensed, fabricated, or modified by a licensed orthotist or licensed prosthetist/orthotist enrolled with Medicare and CCP. The following applies:

- Upper extremity customized splints made with low-temperature materials and inhibitive casting may be provided by occupational or physical therapists.
- Other orthopedic devices addressed in the orthotic section may be provided by a Medicaid-enrolled DME vendor.
- Orthopedic shoes must be provided by a shoe vendor enrolled as a DME provider.

The date of service for a custom-made or custom-fitted orthosis is the date the supplier places an order for the equipment and incurs liability for the equipment. The custom-made or custom-fitted orthosis will be eligible for reimbursement as long as the service is provided during a month the client is eligible for Medicaid.

The following items and services are included in the reimbursement for an orthotic device and not reimbursed separately:

- Client evaluation, measurement, casting, or fitting of the orthosis.
- Repairs due to normal wear and tear during the 90 days following delivery.
- Adjustments or modifications of the orthotic device made when fitting the orthosis and for 90 days from the date of delivery (adjustments and modifications during the first 90 days are considered part of the purchase of the initial device).
Orthopedic shoes that are attached to a brace must be billed by the vendor that bills for the brace. Reimbursement for lifts and wedges may include the cost of the prescription shoe.

2.8.2.1.1 Noncovered Orthotic Services

The following circumstances are not a benefit of Texas Medicaid:

- Orthoses whose sole purpose is for restraint
- Orthoses provided solely for use during sports-related activities in the absence of an acute injury or other indicated medical condition
- Orthotic devices prescribed by a chiropractor

Diagnoses that are not considered medically necessary include, but are not limited to, the following:

- Tired feet
- Fatigued feet
- Nonsevere bow legs
- Valgus deformity of the foot, except as outlined in the orthotic section
- Pes planus (flat feet), except when there is a coexisting medical condition as outlined in the orthotic section

Orthopedic shoes with deluxe features, such as special colors, special leathers, and special styles, are not considered medically necessary, and the features do not contribute to the accommodative or therapeutic function of the shoe.

A foot-drop splint and recumbent positioning device and replacement interface are not considered medically necessary in a client with foot drop who is nonambulatory, because there are other more appropriate treatment modalities.

A static ankle-foot orthosis (AFO) or AFO component is not medically necessary if:

- The contracture is fixed.
- The client has foot drop without an ankle flexion contracture.
- The component is used to address knee or hip positioning, because the effectiveness of this type of component is not established.

A pneumatic thoracic-lumbar-sacral orthosis is considered experimental and investigational and is not a benefit of Texas Medicaid.

2.8.2.2 Prior Authorization and Documentation Requirements

Prior authorization is required for all orthoses and related services.

Before submitting a request for prior authorization for orthosis, the orthosis provider must have a completed CCP Prior Authorization Form requesting the orthosis or related services that has been signed and dated by a physician who is familiar with the client. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates will not be accepted. The completed CCP Prior Authorization Form must include the procedure codes and quantities for requested services. A copy of the completed, signed, and dated form must be maintained by the orthosis provider in the client’s medical record. The completed CCP Prior Authorization Form with the original dated signature must be maintained by the prescribing physician in the client’s medical record.

- To complete the prior authorization process electronically, the orthosis provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the
signed and dated CCP Prior Authorization Request form in the client’s medical record at the provider’s place of business.

- To complete the prior authorization process by paper, the orthosis provider must fax or mail the completed CCP Prior Authorization Request Form to the CCP prior authorization unit and retain a copy of the signed and dated CCP form in the client’s medical record at the provider’s place of business.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment and supplies requested. The physician must maintain documentation of medical necessity in the client’s medical record. The provider may be asked for additional information to clarify or complete a request for the service or device.

All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the device is needed for one of the following general indications:

- To reduce pain by restricting mobility of the affected body part.
- To facilitate healing following an injury to the affected body part or related soft tissue.
- To facilitate healing following a surgical procedure on the affected body part or related soft tissue.
- To support weak muscles or a deformity of the affected body part.

Prior authorization requests for some types of orthosis require additional documentation. See the appropriate sections for additional documentation needed for each service.

The provider must keep the following written documentation in the client’s medical record:

- The prescription for the device.
  - Orthotic devices must be prescribed by a physician (M.D. or D.O.) or a podiatrist. A podiatrist prescription is valid for conditions of the ankle and foot.
  - The prescription must be dated on or before the initial date of the requested dates of service, which can be no longer than 90 days from the signature date on the prescription.
  - Accurate diagnostic information that supports the medical necessity for the requested device. A retrospective review may be performed to ensure that the documentation included in the client’s medical record supports the medical necessity of the requested service or device.

A prior authorization is valid for a maximum period of six months from the prescription signature date. At the end of the six-month authorization period, a new prescription is required for prior authorization of additional services.

The actual date of service is the date the supplier has placed an order for the equipment and has incurred liability for the equipment.

2.8.2.2.1 Spinal Orthoses

Spinal orthoses include, but are not limited to, cervical orthoses, thoracic rib belts, thoracic-lumbar-sacral orthoses (TLSO), sacroiliac orthoses, lumbar orthoses, lumbar-sacral orthoses (LSO), cervical-thoracic-lumbar-sacral orthoses (CTLSO), halo procedures, spinal corset orthoses, and spinal orthoses for scoliosis.

Spinal orthoses will be considered for prior authorization with documentation of one of the general indications.
2.8.2.2 Lower-Limb Orthoses

Lower-limb orthoses include, but are not limited to, hip orthoses (HO), Legg Perthes orthoses, knee orthoses (KO), ankle-foot orthoses (AFO), knee-ankle-orthoses (KAFO), hip-knee-ankle-foot orthoses (HKAFO), fracture orthoses, and reciprocating gait orthoses (RGO).

In addition to the general indication requirements, lower-limb orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices:

Ankle-Foot Orthoses

AFOs used during ambulation will be considered for prior authorization for clients with documentation of all of the following:

- Weakness or deformity of the foot and ankle.
- A need for stabilization for medical reasons.
- Anticipated improvement in functioning during activities of daily living (ADLs) with use of the device.

AFOs not used during ambulation (static AFO) will be considered for prior authorization for clients with documentation of one of the following conditions:

- Plantar fasciitis.
- Plantar flexion contracture of the ankle, with additional documentation that includes all of the following:
  - Dorsiflexion on pretreatment passive range of motion testing is at least ten degrees.
  - The contracture is interfering or is expected to interfere significantly with the client’s functioning during ADLs.
  - The AFO will be used as a component of a physician-prescribed therapy plan care, which includes active stretching of the involved muscles or tendons.
  - There is reasonable expectation that the AFO will correct the contracture.

Knee-Ankle-Foot Orthoses

KAFOs used during ambulation will be considered for prior authorization for clients with documentation that supports medical necessity for additional knee stabilization.

KAFOs that are custom-fabricated (molded-to-patient model) for ambulation will be considered for prior authorization when at least one of the following criteria is met:

- The client cannot be fit with a prefabricated AFO/KAFO.
- The condition that necessitates the orthosis is expected to be permanent or of long-standing duration (more than six months).
- There is a need to control the knee, ankle, or foot in more than one plane.
- The client has a documented neurological, circulatory, or orthopedic status that requires custom fabrication to prevent tissue injury.
- The client has a healing fracture that lacks normal anatomical integrity or anthropometric proportions.

Reciprocating Gait Orthoses

Reciprocating gait orthoses will be considered for prior authorization for clients with spina bifida or similar functional disabilities.
The prior authorization request must include a statement from the prescribing physician that indicates medical necessity for the RGO, the PT treatment plan, and documentation that the client and family are willing to comply with the treatment plan.

2.8.2.2.3 Foot Orthoses

Foot orthoses include, but are not limited to, foot inserts, orthopedic shoes, wedges, and lifts.

Foot orthoses will be considered for prior authorization for clients with documentation of all the following:

- The client has symptoms associated with the particular foot condition.
- The client has failed to respond to a course of appropriate, conservative treatment, including PT, injections, strapping, or anti-inflammatory medications.
- The client has at least one of the following:
  - Torsional conditions, such as metatarsus adductus, tibial torsion, or femoral torsion.
  - Structural deformities.
  - Hallux valgus deformities.
  - In-toe or out-toe gait.
  - Musculoskeletal weakness.

In addition to the general indication requirements, foot orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices:

**Foot Inserts**

Removable foot inserts will be considered for prior authorization for clients with documentation of at least one of the following medical conditions:

- Diabetes mellitus.
- History of amputation of the opposite foot or part of either foot.
- History of foot ulceration or pre-ulcerative calluses of either foot.
- Peripheral neuropathy with evidence of callus formation of either foot.
- Deformity of either foot.
- Poor circulation of either foot.

Removable foot inserts may be covered independently of orthopedic shoes with documentation that the client has appropriate footwear into which the insert can be placed.

A University of California at Berkeley (UCB) removable foot insert will be considered for prior authorization with documentation that the device is required to correct or treat at least one of the following conditions:

- A valgus deformity and significant congenital pes planus with pain.
- A structural problem that results in significant pes planus, such as Down syndrome.
- Acute plantar fasciitis.

**Orthopedic Shoes**

Orthopedic shoes must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist. An orthopedic shoe is used by clients whose feet, although impaired, are essentially intact. An orthopedic shoe differs from a prosthetic shoe, which is used by clients who are missing all or most of the forefoot.
Orthopedic shoes will be considered for prior authorization when at least one of the following criteria is met:

- The shoe is permanently attached to a brace.
- The shoe is necessary to hold a surgical correction, postoperative casting, or serial or clubfoot casting.

An orthopedic shoe may be prior authorized up to one year from the date of the surgical procedure. Only one pair of orthopedic shoes will be prior authorized every three months. Two pairs of shoes may be purchased at the same time; in such situations, however, additional requests for shoes will not be considered for another six months.

Requests for orthopedic shoes that do not meet the criteria listed above may be considered for prior authorization with documentation of medical necessity.

**Wedges and Lifts**

Wedges and lifts must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist and must be for treatment of unequal leg length greater than one-half inch.

**2.8.2.2.4 Upper-Limb Orthoses**

Upper-limb orthoses include, but are not limited to, shoulder orthoses (SO), elbow orthoses (EO), elbow-wrist-hand orthoses (EWHO), elbow-wrist-hand-finger orthoses (EWHFO), wrist-hand-finger orthoses (WHFO), wrist-hand orthoses (WHO), hand-finger orthoses (HFO), finger orthoses (FO), shoulder-elbow-wrist-hand orthoses (SEWHO), shoulder-elbow orthoses (SEO), and fracture orthoses.

In addition to the general indication requirements, upper-limb orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices.

**2.8.2.2.5 Other Orthopedic Devices**

**Protective Helmets**

Protective helmets will be considered for prior authorization for clients with a documented medical condition that makes the client susceptible to injury during ADLs. Covered medical conditions include the following:

- Neoplasm of the brain
- Subarachnoid hemorrhage
- Epilepsy
- Cerebral palsy

Requests for all conditions other than those listed above require submission of additional documentation that supports the medical necessity of the requested device.

**Dynamic Splints**

Static and dynamic mechanical stretching devices will be considered for prior authorization for a four-month rental period when the request is submitted with the following documentation:

- Client’s condition
- Client’s current course of therapy
- Rationale for the use of the static or dynamic mechanical stretching device
- Agreement by the client or family that the client will comply with the prescribed use of the static or dynamic mechanical stretching device
After completion of the four-month rental period, the provider may submit a request for purchase of the static or dynamic mechanical stretching device. Requests for purchase of the static or dynamic mechanical stretching device must include documentation that the four-month rental period was successful and showed improvement in the client’s condition as measured by the following:

- Demonstrated increase in range of motion
- Demonstrated improvement in the ability to complete ADLs or perform activities outside the home

2.8.2.6 Related Services

Repairs, Replacements, and Modifications to Orthoses

Within the guarantee of the manufacturer, providers are responsible, without charge to the client or to Texas Medicaid, for replacement or repair of equipment or any part thereof that is found to be nonfunctional because of faulty material or workmanship.

Service and repairs must be handled under any warranty coverage an item may have. If there is no warranty, providers may request prior authorization for the necessary service and repairs.

A repair because of normal wear or a modification because of growth or change in medical status will be considered for prior authorization if it proves to be more cost effective than replacing the device.

The request for repairs must include a breakdown of charges for parts and the number of hours of labor required to complete the repairs. No charge is allowed for pickup or delivery of the item or for the assembly of Medicaid-reimbursed parts. The following information must be submitted with the request:

- The description and procedure code of the item being serviced or repaired.
- The age of the item.
- The number of times the item has been previously repaired.
- The replacement cost for the item.

The anticipated life expectancy of an orthotic device is six months. Requests for prior authorization for the replacement of a device before its usual life expectancy has ended must include documentation that explains the need for the replacement.

Replacement of orthotic equipment will be considered when the item is out of warranty and repairing the item is no longer cost-effective or when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted with the prior authorization request.

2.8.3 Cranial Molding Orthosis

2.8.3.1 Services, Benefits, and Limitations

Cranial molding orthosis (procedure code S1040) may be a benefit when all of the following criteria are met:

- The client is CCP eligible.
- The client is 3 through 18 months of age.
- The client requires a cranial molding orthosis as part of the treatment plan for a documented diagnosis of synostotic plagiocephaly (diagnosis code 7560).

The limitation for procedure code S1040 is one device per lifetime.

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

A cranial molding orthosis that is used for the treatment of positional plagiocephaly is considered cosmetic, and therefore is not a benefit of Texas Medicaid.

The effective use of a cranial molding orthosis for the treatment of brachycephaly, or a high cephalic index without cranial asymmetry has not been clearly documented, is not medically necessary, and therefore is not a benefit of Texas Medicaid.

2.8.3.3 Prior Authorization and Documentation Requirements

Cranial molding orthoses do not require prior authorization for clients with a diagnosis of synostotic plagiocephaly (diagnosis code 7560). Documentation of medical necessity must be maintained in the client’s medical record.

Prior authorization requests for a cranial molding orthosis for congenital conditions that are not outlined in this section may be considered by the Medical Director on a case-by-case basis with documentation of medical necessity. Additional devices beyond the once-per-lifetime benefit may be considered for prior authorization with documentation of all of the following:

- The initial device was obtained to treat synostotic plagiocephaly.
- Treatment with the device has been effective.
- The new device is needed due to growth.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the equipment requested. The physician must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for an additional cranial molding orthosis.

The completed CCP Prior Authorization Form, which includes the DME must be signed and dated by the prescribing physician familiar with the client’s condition. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed CCP Prior Authorization Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept by the physician in the client’s medical record.

2.8.4 Thoracic-Hip-Knee-Ankle Orthoses (THKAO) (Vertical or Dynamic Standers, Standing Frames, Braces, and Parapodiums)

2.8.4.1 Services, Benefits, and Limitations

THKAO (vertical or dynamic standers, standing frames or braces, and parapodiums), including all accessories, require prior authorization. A THKAO may be considered if the client requires assistance to stand and remain standing.

2.8.4.1.1 Parapodium

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

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

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

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

Providers must use procedure code E0638 for a standing frame or brace.

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

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

2.8.4.2 Prior Authorization and Documentation Requirements
THKAO (vertical or dynamic standers, standing frames or braces, and parapodiums), including all accessories, requires prior authorization.

THKAO may be considered for clients who are CCP-eligible and who require assistance to stand and remain standing when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client’s disability or physical or mental illness or condition.

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

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

2.8.5 Prosthetic Services

2.8.5.1 Services, Benefits, and Limitations
External prostheses are a benefit of Texas Medicaid when provided by a licensed prosthetist or licensed prosthetist/orthotist through CCP for clients who are birth through 20 years of age.

The following prostheses and related services may be reimbursed when medical necessity criteria are met:

• Lower limb
• Upper limb
• Craniofacial
• External breast
• Repair, replacements, and modifications
• Prosthetic training
• Accessories to prostheses

Prosthetic training by a physical or occupational therapist for a lower limb prosthesis or an upper extremity prosthesis is a benefit for clients who have not worn one previously or for a prolonged period or who are receiving a different type.

Refer to: Subsection 2.11, “Therapy Services (CCP)” in this handbook for more information on physical and occupational therapy services.

To be considered for reimbursement, prostheses must be dispensed, fabricated, or modified by a licensed prosthetist or licensed prosthetist/orthotist enrolled with Medicare and CCP.

The date of service for a custom-made or custom-fitted prosthesis is the date the supplier places an order for the equipment and incurs a liability for the equipment. The custom-made or custom-fitted prosthesis will be eligible for reimbursement as long as the service is provided during a month the client is eligible for Medicaid.

The following items and services are included in the reimbursement for a prosthetic device and not reimbursed separately:

• Evaluation of the residual limb and gait
• Measurement, casting, or fitting of the prosthesis
• Cost of base component parts and labor contained in the base procedure code description
• Repairs due to normal wear and tear during the 90 days following delivery
• Adjustments or modifications of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the client’s functional ability

In general, base codes do not represent a complete device. To include the additional components necessary for a complete device, providers may bill additional components with a code that is used in addition to a base code. Addition codes may also be used to indicate modifications to a device. The values assigned to the additional codes do not represent the actual value of the component or modification, but only the difference between the total value and the value of the base code. As a result, reimbursement of an addition does not involve subtraction of any amounts from the base code allowance.

2.8.5.1 Noncovered Prosthetic Services

Prosthetic devices prescribed by a chiropractor are not a benefit of Texas Medicaid.

A vacuum-assisted socket system (procedure code L5781 or L5782), which is a specialized vacuum pump, is considered experimental and investigational, and is not a benefit of Texas Medicaid.

Myoelectric hand prostheses for conditions other than the absence of forearm(s) and hand(s) are considered experimental and investigational and are not a benefit of Texas Medicaid.

A prosthetic device customized with enhanced features is not considered medically necessary if ADLs can be met with a standard prosthetic device.

Accessories that are not required for the effective use of a prosthetic device are not considered medically necessary.

2.8.5.2 Prior Authorization and Documentation Requirements

Prior authorization is required for all prosthetic devices.
A completed CCP Prior Authorization Form requesting the prosthesis must be signed and dated by a physician familiar with the client before requesting prior authorization for all prostheses. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates will not be accepted. The completed CCP Prior Authorization Form must include the procedure codes and numerical quantities for services requested. A copy of the completed, signed, and dated form must be maintained by the prosthesis provider in the client’s medical record. The completed CCP Prior Authorization Form with the original dated signature must be maintained by the prescribing physician in the client’s medical record.

To complete the prior authorization process by paper, the prosthesis provider must fax or mail the completed CCP Prior Authorization Request Form to the CCP prior authorization unit and retain a copy of the signed and dated CCP form in the client’s medical record at the provider’s place of business.

To complete the prior authorization process electronically, the prosthesis provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated CCP Prior Authorization Request form in the client’s medical record at the provider’s place of business.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment or supplies requested. The physician must maintain documentation of medical necessity in the client’s medical record. The provider may be asked for additional information to clarify or complete a request for the service or device.

All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the client meets the following general indications for the requested device:

- The prosthesis replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the limb, and identification of the specific limb that is being replaced by the prosthesis.
- The prosthesis is required for ADLs or for rehabilitation purposes, and identification of the ADLs or rehabilitation purpose for which the prosthesis is required.

The provider must keep the following written documentation in the client’s medical record:

- The prescription for the device.
- Prosthetic devices must be prescribed by a physician (M.D. or D.O.).
- The prescription must be dated prior to or on the initial date of the requested dates of service, which can be no longer than 90 days from the signature date on the prescription.
- Accurate diagnostic information that supports the medical necessity for the requested device. (A retrospective review may be performed to ensure that the documentation included in the client’s medical record supports the medical necessity of the requested service or device.)
- The specific make, model, and serial number of the prosthetic components.
- The treatment plan outlining the therapy program prescribed by the treating physician, including expected goals with the use of the prosthesis.
- A statement submitted by the physician that indicates that the client or client’s family or caregiver demonstrates willingness to comply with the therapy program.

Prior authorization is valid for a maximum period of six months from the prescription signature date. At the end of the six-month authorization period, a new prescription is required for prior authorization of additional services.
The actual date of service is the date the supplier has placed an order for the equipment and has incurred liability for the equipment.

2.8.5.2.1 * Lower-Limb Prostheses

Lower limb prostheses include, but are not limited to, the following:

- Partial foot, ankle, and knee disarticulation sockets
- Above-knee short prostheses
- Hip and knee disarticulation prostheses
- Postsurgical prostheses
- Preparatory prostheses
- Additions to lower extremity prostheses
- Replacement sockets

A basic lower limb prosthesis consists of the following:

- A socket or connection between the residual limb and the prosthesis
- A suspension mechanism attaching the socket to the prosthesis
- A knee joint that provides support during stance, smooth control during the swing phase, and unrestricted motion for sitting and kneeling
- An exoskeleton or endoskeleton pylon (tube or shell) that attaches the socket to the terminal device
- A terminal device (foot)

In addition to the general indication requirements, the following additional documentation is also required for all lower limb prostheses:

- Written documentation of the client’s current and potential functional levels. A functional level is defined as a measurement of the capacity and potential of the individuals to accomplish their expected post-rehabilitation daily function. The potential functional ability is based on reasonable expectations of the treating physician and the prosthetist and includes, but is not limited to, the following:
  - The client’s history, including prior use of a prosthesis if applicable
  - The client’s current condition, including the status of the residual limb and any coexisting medical conditions
  - The client’s motivation to ambulate and ability to achieve independent transfers or ambulation with the use of a lower limb prosthesis

The following functional classification levels have been defined by the Centers for Medicare & Medicaid Services (CMS):

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>Does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance quality of life or mobility.</td>
</tr>
<tr>
<td>Level 1</td>
<td>Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator</td>
</tr>
<tr>
<td>Level 2</td>
<td>Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.</td>
</tr>
</tbody>
</table>
A client whose functional level is zero (0) is not a candidate for a prosthetic device; the device is not considered medically necessary.

**Microprocessor-Controlled Lower Limb Prostheses**

Microprocessor-controlled lower limb prostheses (e.g., Otto Bock C-Leg, Intelligent Prosthesis, or Ossur Rheo Knee) will be considered for prior authorization for clients who have a transfemoral amputation from a nonvascular cause, such as trauma or tumor and a functional level of 3 or above, and who meet the following criteria:

- The individual has adequate cardiovascular reserve and cognitive learning ability to master the higher level of technology and to allow for faster than normal walking speed.
- The individual demonstrates the ability to ambulate at a faster than baseline rate using a standard prosthetic application with a swing and stance control knee.
- The individual has a demonstrated need for long-distance ambulation at variable rates (greater than 400 yards) on a daily basis. Use of the limb in the home or for basic community ambulation is not sufficient to justify provision of the computerized limb instead of standard limb applications.
- The individual has a demonstrated need for regular ambulation on uneven terrain or for regular use on stairs. Use of the limb for limited stair climbing in the home or employment environment is not sufficient evidence for prescription of this device over standard prosthetic application.

The licensed prosthetist or licensed prosthetist/orthotist providing the device must be trained in the fitting and programming of the microprocessor-controlled prosthetic device.

**Foot Prostheses**

The following foot prostheses will be considered for prior authorization for clients whose documented functional level is 1 or above:

- A solid ankle-cushion heel (SACH) foot
- An external keel SACH foot or single axis ankle/foot

A flexible-keel foot or multi-axial ankle/foot will be considered for prior authorization for clients whose documented functional level is 2 or above.

A flex foot system, energy storing foot, multiaxial ankle/foot, dynamic response, or flex-walk system or equivalent will be considered for prior authorization for clients whose documented functional level is 3 or above.

A prosthetic shoe will be considered for prior authorization if it is an integral part of a prosthesis for clients with a partial foot amputation.

**Ankle Prosthesis**

An axial rotation unit will be considered for prior authorization for clients whose documented functional level is 2 or above.
Knee Prosthesis
A single-axis, constant-friction knee and other basic knee systems will be considered for prior authorization for clients whose documented functional level is 1 or above. A fluid, pneumatic, or electronic knee prosthesis will be considered for prior authorization for clients whose documented functional level is 3 or above. A high-activity knee control frame will be considered for prior authorization for clients whose documented functional level is 4.

Prosthetic Substitutions or Additions for Below-Knee Prostheses
Prosthetic substitutions or additions (procedure codes L5629, L5638, L5639, L5646, L5647, L5704, L5785, L5962, and L5980) are not considered medically necessary when an initial below-knee prosthesis (procedure code L5500) or a preparatory below-knee prosthesis (procedure codes L5510, L5520, L5530, or L5540) is provided.

Prosthetic substitutions or additions (procedure codes L5620, L5629, L5645, L5646, L5670, L5676, L5704, and L5962) are not considered medically necessary when a below-knee preparatory, prefabricated prosthesis (procedure code L5535) is provided.

Sockets
Prior authorization for test (diagnostic) sockets for an individual prosthesis is limited to a quantity of two test sockets. Prior authorization for same-socket inserts for an individual prosthesis is also limited to a quantity of two. Requests for test sockets or same-socket inserts beyond these limitations must include documentation of medical necessity that supports the need for the additional sockets.

2.8.5.2.2 Upper-Limb Prostheses
Upper limb prostheses include, but are not limited to, the following:

- Partial hand prostheses
- Wrist and elbow disarticulation prostheses
- Shoulder and interscapular thoracic prostheses
- Immediate postsurgical or early fitting prostheses
- Preparatory prostheses
- Terminal devices
- Replacement sockets
- Inner sockets-externally powered
- Electric hand, wrist, and elbow prostheses

Upper limb prostheses will be considered for prior authorization with documentation of all of the general indication requirements. The additional criteria in the following sections apply for specific prosthetic devices.

Myoelectric Upper Limb Prostheses
A myoelectric upper limb prosthetic device is considered medically necessary when all of the following criteria have been met:

- The client has sufficient neurological, myocutaneous, and cognitive function to operate the prosthesis effectively.
- The client has an amputation or missing limb at the wrist or above (e.g., forearm, elbow, and so on).
- The client is free of comorbidities that could interfere with maintaining function of the prostheses (e.g., neuromuscular disease).
- The client retains sufficient microvolt threshold in the residual limb to allow proper function of the prostheses.
• Standard body-powered prosthetic devices cannot be used or are insufficient to meet the functional needs of the patient in performing ADLs.

• The client does not function in an environment that would inhibit function of the prosthesis (e.g., a wet environment or a situation involving electrical discharges that would affect the prosthesis).

2.8.5.2.3 External Breast Prostheses
External breast prostheses will be considered for prior authorization for clients who have congenital absence of a breast or who have had a mastectomy.

2.8.5.2.4 Craniofacial Prostheses
Craniofacial prostheses include, but are not limited to, external nasal, ear, and facial prostheses.
Craniofacial prostheses will be considered for prior authorization with documentation that the device is necessary to correct an absence or deformity of the affected body part.

2.8.5.2.5 Related Services

Accessories to Prostheses
Accessories to prostheses, such as stump stockings and harnesses will be considered for prior authorization when they are essential to the effective use of the prosthetic device.

Repairs, Replacements, and Modifications to Prostheses
Repairs due to normal wear and tear will be considered for prior authorization after 90 days from the date of delivery of the initial prosthesis, when the repair is:

• Necessary to make the equipment functional.

• More cost-effective than the replacement of the prosthetic device.

Providers must include documentation that supports medical necessity when they request prior authorization. Additional information from the provider may be requested to determine cost-effectiveness.

Replacement of prosthetic equipment will be considered for coverage when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate and the measures to be taken to prevent re-occurrence must be submitted with the prior authorization request.

Socket replacements will be considered for prior authorization with documentation of functional or physiological need, including, but not limited to, changes in the residual limb, functional need changes, or irreparable damage or wear due to excessive weight or prosthetic demands of very active amputees.

Children typically require new prosthetic devices every 12 to 18 months, although the actual lifespan of a device depends on the child’s rate of skeletal growth. Prosthetic devices for children must accommodate growth and other physiological changes.

Components and systems that allow for growth or increase the lifespan of the prosthesis may include the following:

• Growth-oriented suspension systems and modifications

• Use of modular systems

• Use of flexible sockets

• Use of removable sockets (slip or triple-wall sockets)

• Use of distal pads

• Modification of socket liners

• Increasing or decreasing sock thickness
Modifications due to growth or change in medical status will be considered for prior authorization with documentation of medical necessity.

Medical necessity for requested components or additions to the prosthesis is based on the client’s current functional ability and the expected functional potential as defined by the prosthetist and the ordering physician.

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

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

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

Refer to: Form CH.29, “Orthotic and Prosthetic Services (CCP Only)” in this handbook for a claim form example.

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

2.9 Personal Care Services (PCS) (CCP)

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

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

LCHH agencies that are currently enrolled through TMHP do not need to enroll as a CCP-PCS provider.

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

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

- Personal Assistance Services (PAS)
- Licensed Home Health Services (LHHS)
- Licensed and Certified Home Health Services (LCHHS)

Additionally, providers must have a TPI in one of the following enrollment categories: LHHS agency, LCHHS agency, or PCS provider.
Providers that are enrolled as any entity other than an LHHS agency or LCHHS agency are required to meet the provider enrollment rules in order to participate in the delivery of PCS through Texas Medicaid.

Refer to: Subsection 2.1.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.

2.9.2 Services, Benefits, and Limitations

PCS is a benefit of CCP for Texas Medicaid clients who are birth through 20 years of age and who are not inpatients or residents of a hospital, in a nursing facility or intermediate care facility for persons with intellectual disabilities (ICF/ID), or in an institution for mental disease. PCS will be denied when billed on the same date of service as an inpatient stay service. The provider may appeal the denied claim with documentation supporting that PCS was performed while the client was not in a hospital setting. PCS are support services provided to clients who meet the definition of medical necessity and require assistance with the performance of ADLs, instrumental activities of daily living (IADLs), and health-related functions due to a physical, cognitive, or behavioral limitation related to a client’s disability or chronic health condition. PCS are provided by someone other than the legal responsible adult of the client who is a minor child or the legal spouse of the client.

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

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

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

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

* Medical transportation includes the coordination of transportation to medical appointments and accompaniment to appointments. PCS does not include the payment for transportation or transportation vehicles since these services are available through MTP.
Note: Exercise and range of motion are not available through PCS, but are services that could be provided through PT, PDN, or home health SN.

PCS do not include the following:

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

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

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

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

<table>
<thead>
<tr>
<th>PCS Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All PCS Providers</strong> (except CDSA)</td>
</tr>
<tr>
<td>Procedure Code</td>
</tr>
<tr>
<td>Modifier</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>CDSA Under CDS Option</strong></td>
</tr>
<tr>
<td>Procedure Code</td>
</tr>
<tr>
<td>Modifier</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

* 40 TAC Part 1, Chapter 41
2.9.2.1 Place of Services

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

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

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

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

2.9.2.2 Client Eligibility

The PCS benefit is available to Texas Medicaid clients who:

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

When the client has a functional condition that meets the criteria for PCS, the following needs of the client’s responsible adult will be considered:

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

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

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

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

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

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

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

2.9.2.2.1 Accessing the PCS Benefit

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

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

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

Upon receiving a referral, DSHS assigns the client a case manager, who then conducts an assessment in the client’s home with the input and assistance of the client or responsible adult. Based on the assessment, the case manager identifies whether the client has a need for PCS. If the case manager identifies a need for PCS, the client or responsible adult is asked to select a Medicaid-enrolled PCS provider in their area.

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

2.9.2.2.2 The Primary Practitioner’s Role in the PCS Benefit

A client who is assessed for the PCS benefit must have a primary practitioner (a licensed physician, APRN, or PA) or a primary care provider who has a therapeutic relationship and ongoing clinical knowledge of the client. The primary practitioner or primary care provider must have established a diagnosis for the client and must provide continuing care and medical supervision of the client. When the DSHS case manager has determined the client has a need for the PCS benefit, the case manager contacts the client’s primary practitioner or primary care provider to obtain a Practitioner Statement of Need (PSON). The PSON certifies the client has a physical, cognitive, or behavioral limitation related to a disability or chronic health condition and is birth through 20 years of age. The PSON must be signed
and dated by the primary practitioner or primary care provider within 60 days of the initial start of care (SOC). If the PSON is not received within 60 days, the services will be terminated or denied. The primary practitioner or primary care provider must mail or fax the completed PSON to the appropriate DSHS Health Services Region. DSHS keeps the signed and dated PSON in the client’s case management record for the duration of the client’s participation in the benefit.

When a behavioral health condition exists, the primary practitioner may be a behavioral health provider. The primary practitioner must maintain the PSON in the client’s medical record.

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

2.9.2.3 PCS Provided in Group Settings

PCS may be provided in a provider to client ratio other than one-to-one. Only the time spent on direct PCS for each client may be billed. Total PCS billed for all clients cannot exceed the individual provider’s total number of hours spent at the POS. PCS may be provided by more than one attendant to an individual client, or PCS may be provided to more than one client by one attendant. Settings in which providers can provide PCS in a provider to client ratio other than one-to-one include homes with more than one client needing PCS, foster homes, and independent living arrangements.

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

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

**Example:** If the prior authorized PCS hours for Client A is four hours, Client B is six hours, and the actual time spent with both clients is eight hours, the provider must bill for the actual one-on-one time spent with each client, not to exceed the client’s prior authorized hours or total hours worked. It would be acceptable to bill four hours for Client A and four hours for Client B, or three hours for Client A and five hours for Client B. It would not be acceptable to bill five hours for Client A and three hours for Client B. It would be acceptable to bill ten hours if the individual person actually spent ten hours onsite providing prior authorized PCS split as four hours for Client A and six hours for Client B. A total of ten hours cannot be billed if the individual person worked only eight hours.

When there is more than one client within the same household receiving PCS, the DSHS case manager will synchronize authorizations within the households for all eligible clients. The DSHS case manager will assess all eligible clients in the home and submit authorizations for all eligible clients in the household for the same 52-week authorization period. DSHS case managers will communicate with the provider the actions that are being taken using the existing Communication Tool.

**Note:** There should be no lapse in services to the client.

2.9.3 Prior Authorization and Documentation Requirements

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

A PCS provider may obtain prior authorization to provide enhanced PCS to clients with a behavioral health condition when the following criteria are met:
• The DSHS case manager completes the Personal Care Assessment Form (PCAF) and identifies the health condition.

• The PCAF indicates that the identified behavioral health condition impacts the client’s ability to perform an ADL or IADL.

• The PCAF indicates which ADL(s) or IADL(s) cannot be performed by the client without assistance.

• The DSHS case manager submits the appropriate modifier on the authorization request.

When a client experiences a change in condition, the client or responsible adult must notify the DSHS Health Service Office in the client’s region. A DSHS case manager must perform a new assessment and prior authorize any revisions in the quantity of PCS based on the new assessment. TMHP issues a revised authorization and notifications are sent to the client or responsible adult and the selected PCS provider. If the change is made during a current 12-month prior authorization period, the new prior authorization will maintain the same end date as the original 12-month prior authorization period. The revised authorization period will begin on the SOC date stated in the new assessment.

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

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

### 2.9.3.1 PCS Provider Responsibilities

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

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

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

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

### 2.9.3.2 Documentation of Services Provided and Retrospective Review

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

• All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.

• Each page of the record documents the client’s name and Medicaid identification number.

• All attendants’ arrival and departure times are documented with signature and time.

• Documentation of services correlates with, and reflects medical necessity for, the services provided on any given day.
• Client’s arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client.

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

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

2.9.4.1 Managed Care Clients
PCS services are carved-out of the Medicaid Managed Care Program for State of Texas Access Reform (STAR) clients and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client’s MCO. Claims for STAR Health and STAR+PLUS are not carved out and must be submitted to the client’s MCO for payment consideration.

2.9.4.2 PCS for STAR Health Clients
Personal care services for children and youth are authorized and processed by Superior HealthPlan. Medicaid providers that want to provide PCS services to clients in the STAR Health program should contact Superior HealthPlan for information regarding the contracting and credentialing process at:

Superior HealthPlan - Network Development
Telephone: 1-866-615-9399 Ext. 22534
Email: shp-networkdevelopment@centene.com

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

2.10 Private Duty Nursing (PDN)(CCP)
2.10.1 Enrollment
Home health agencies may enroll to provide PDN under CCP. RNs and licensed vocational nurses (LVNs) may enroll independently to provide PDN under CCP.

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

Independently-enrolled RNs and LVNs must be enrolled as providers in CCP and comply with all of the following:
• The terms of the Texas Medicaid Provider Agreement
Independently enrolled RNs and LVNs must also:

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

Independently enrolled RNs must:

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

Independently enrolled LVNs must:

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

Refer to: Subsection 2.1.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.

### 2.10.2 Services, Benefits, and Limitations

Medicaid clients who are birth through 20 years of age are entitled to all medically necessary PDN services and home health SN services.

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

Nursing services are medically necessary under the following conditions:

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

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

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

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

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independently Enrolled RNs/LVNs</td>
<td></td>
</tr>
<tr>
<td>T1000 with modifier TD or TE</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Home Health Agencies</td>
<td></td>
</tr>
<tr>
<td>T1000 with modifier TD or TE</td>
<td>15 minutes</td>
</tr>
<tr>
<td>T1002</td>
<td>15 minutes</td>
</tr>
<tr>
<td>T1003</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

Note: Indepependentlv-enrolled LVNs must use the TE modifier, and independently-enrolled RNs must use the TD modifier.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PDN and SN must not be routinely performed on the same date during the same time period.

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

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

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

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

2.10.2.2 Criteria

2.10.2.2.1 Client Eligibility Criteria

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

- Be birth through 20 years of age and eligible for Medicaid and THSteps
- Meet medical necessity criteria for PDN
- Have a primary physician who must:
  - Provide a prescription for PDN.
  - Establish a POC.
  - Provide specific written, dated orders for the client who is receiving continuing or ongoing PDN services.
  - Require care beyond the level of services provided under Texas Medicaid (Title XIX) Home Health Services

  **Note:** The physician visit may be waived when a diagnosis has already been established by the physician, and the client is under the continuing care and medical supervision of the physician. A waiver is valid for no more than 365 days, and the client must be seen by his/her physician at least once every 365 days. The waiver must be based on the physician’s written statement that an additional evaluation visit is not medically necessary. This documentation must be maintained by the physician and the provider in the client’s medical record.

- Provide continuing medical care and supervision of the client, including, but not limited to, examination or treatment within 30 calendar days prior to the start of PDN services, or examination or treatment that complies with the THSteps periodicity schedule, or is within six months of the PDN extension SOC date, whichever is more frequent (for extensions of PDN services). This requirement may be waived based on review of the client’s specific circumstances.
Clients who are birth through 17 years of age must reside with a responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

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

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

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

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

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

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

2.10.3 Prior Authorization and Documentation Requirements
A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

A CNM, CNS, NP, or PA may sign all documentation related to the provision of private duty nursing services on behalf of the client’s physician when the physician delegates this authority.

All signatures must be current, unaltered, original, and handwritten; computerized or stamped signatures will not be accepted. All documentation must be maintained by the requesting PDN provider. The PDN provider may be asked to submit additional documentation to support medical necessity.

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

- Clearly and consistently describe the client’s current diagnosis, functional status, and condition.
- Consistently describe the treatment throughout the documentation.
- Provide a sufficient explanation as to how the requested nursing services correct or ameliorate the client’s disability, physical or mental illness, or condition.
When a provider receives a referral for PDN, the provider must have an RN perform a nursing assessment of the client within the client’s home environment. This assessment must be performed before seeking prior authorization for PDN, with any request for PDN recertification, or any request to modify PDN hours.

The assessment must demonstrate the following:

- Medical necessity for PDN.
- Safety of providing care in the proposed setting.
- If birth through 17 years of age, the client resides with a responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.
- “Responsible adult” means an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.
- An identified contingency plan is a structured process designed by the responsible adult and the PDN provider, by which a client will receive care when a scheduled private duty nurse is unexpectedly unavailable, and the responsible adult is unavailable, or is not trained to provide the nursing care. The identified responsible adult must be able to initiate the contingency plan.
- The existing level of care and any additional health-care services including the following: SHARS, MDCP, OT, PT, ST, primary home care (PHC), and case management services.

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

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

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

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

The following criteria are considered for PDN prior authorization:

- The documentation submitted with the request is complete.
- The requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations.
- The explanation of the client’s medical needs is sufficient to support a determination that the requested services correct or ameliorate the client’s disability, physical or mental illness, or chronic condition.
- The client’s nursing needs cannot be met on an intermittent or part-time basis through Texas Medicaid (Title XIX) Home Health Services skilled nursing services.
- There is no TPR financially responsible for the services.

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

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

**Note:** CCP does not prior authorize an SOC date earlier than seven calendar days before contact with TMHP.

Prior authorizations for more than 16 hours per day are not issued to a single, independently-enrolled nurse. Requests for prior authorizations of PDN must always be commensurate with the client’s medical needs. Requests for services must reflect changes in the client’s condition that affect the amount and duration of PDN.

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

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

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

Intermittent SN visits for clients who receive PDN and who require TPN administration education may be considered for separate prior authorization if:

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

The SN services may be prior authorized only for the client and caregiver who will be trained in TPN administration.

Clients whose only SN need is the provision of education for self-administration of prescribed subcutaneous (SQ), intramuscular (IM), or intravenous (IV) injections will not qualify for PDN services. Nursing hours for the sole purpose of providing education to the client and caregiver may be considered through intermittent home health SN visits.

### 2.10.3.1 Retroactive Client Eligibility

Retroactive eligibility occurs when the effective date of a client’s Medicaid coverage is before the date that the client’s Medicaid eligibility is added to TMHP’s eligibility file, which is called the “add date.”

For clients with retroactive eligibility, prior authorization requests must be submitted after the client’s add date and before a claim is submitted to TMHP.
For services provided to Medicaid clients during the client’s retroactive eligibility period (i.e., the period from the effective date to the add date, prior authorization must be obtained within 95 days from the client’s add date and before a claim for those services is submitted to TMHP). For services provided on or after the client’s add date, the provider must obtain prior authorization within three business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to access the Automated Inquiry System (AIS) or TexMedConnect to verify eligibility frequently while providing services to the client. If services are discontinued before the client’s add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

**2.10.3.2 Start of Care (SOC)**

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

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

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

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

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

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

**2.10.3.3 Prior Authorization of Initial Requests**

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

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

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

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

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

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

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

Refer to: Form CH.9, “Nursing Addendum to Plan of Care (CCP) (7 Pages)” in this handbook.
Form CH.4, “CRCP Prior Authorization Request Form” in this handbook.
Form CH.8, “Home Health Plan of Care (POC)” in this handbook.

2.10.3.4 Authorization for Revision of Current Services

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

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

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

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

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

Revision requests for PDN may be prior authorized up to six months.
If all necessary documentation is not submitted for a six-month authorization, an authorization for a period up to three months may be approved.

Revisions to a current certification must fall within the certification period. If the revision extends beyond the current certification period, new authorization documentation must be submitted to CCP.

Refer to: Form CH.9, “Nursing Addendum to Plan of Care (CCP) (7 Pages)” in this handbook.
Form CH.4, “CRCP Prior Authorization Request Form” in this handbook.
Form CH.8, “Home Health Plan of Care (POC)” in this handbook.

2.10.3.5 Recertifications of Authorizations

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

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

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

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

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

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

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

All authorization timelines apply to recertifications also.

Refer to:
Form CH.9, “Nursing Addendum to Plan of Care (CCP) (7 Pages)” in this handbook.
Form CH.4, “CRCP Prior Authorization Request Form” in this handbook.
Form CH.8, “Home Health Plan of Care (POC)” in this handbook.

2.10.3.6 Termination of Authorization
An authorization may be terminated when the:
• Client is no longer eligible for CCP or Medicaid.
• Client no longer meets the medical necessity criteria for PDN.
• POS can no longer accommodate the client’s health and safety.
• Client or responsible adult refuses to comply with the service plan and compliance is necessary to ensure the client’s health and safety.

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

CCP notifies the client and provider in writing when the following instances occur:
• PDN is denied.
• PDN hours authorized are less than the hours requested on the POC.
• PDN hours are modified (e.g., hours are requested by the week but are authorized by the day).
• CCP receives incomplete information from the provider.
• Dates of service authorized are different from those requested.
• The provider is responsible for notification and coordination with the physician and family.
2.10.3.8 Authorization Appeals

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

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

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

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

- Form CH.2, “CCP Prior Authorization Request Form” in this handbook
- Form CH.8, “Home Health Plan of Care (POC)” in this handbook
- Form CH.9, “Nursing Addendum to Plan of Care (CCP) (7 Pages)” in this handbook

2.10.3.9 CCP Prior Authorization Request Form

The CCP Prior Authorization Request Form must be completed, signed, and dated by the physician. When PDN services are ordered, by signing the form the physician attests and certifies the client’s medical condition is sufficiently stable to permit safe delivery of PDN as described in the plan of care. All requested dates of service must be included.

2.10.3.10 Home Health Plan of Care (POC)

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

Pursuant to 42 CFR §484.18, the POC must include the following elements:

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

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

**2.10.3.11 Nursing Addendum to Plan of Care (CCP) Form**

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

The following is a description of the nursing care plan summary:

• The nursing care summary is not a complete nursing care plan.

• Information must be client-focused and detailed.

• The problem list must reflect the reasons that nursing services are needed. The problem list is not the nursing care plan. Providers must identify two-to-four current priority problems from their nursing care plan. The problem does not need to be stated as a nursing diagnosis. The problems listed must focus on the primary reasons that a licensed nurse is required to care for the client. Other attached documents are not accepted in lieu of this section.

• The Goals must relate directly to the problems listed and be client-specific and measurable. Goals may be short- or long-term; however, for many clients who receive PDN, the goals generally are long-term.

• The Outcomes are the effects of the provider’s nursing interventions and must be measurable. Generally, these are more short-term than goals. For initial requests, list expected outcomes. Extension requests should note the results of nursing interventions.

• The Progress must be viewed as a “yardstick” or continuum on which progress toward goals is marked. Initial requests must state expected progress for the authorization period. Extension requests must list the progress noted during the previous authorization period. It is recognized that all progress may not be positive.

• The addendum must summarize the client’s health problems relating to the medical necessity for PDN.

• The addendum must clearly communicate a picture of the client’s overall condition and nursing care needs.

• The summary of recent health history is imperative in determining whether the client’s condition is stable or if new nursing care needs have been identified. This section gives the PDN provider an opportunity to describe the client’s recent health problems, including acute episodes of illness, hospitalizations, injuries, and so on. The summary should create a complete picture of the client’s condition and nursing care needs. The summary may cover the previous 90 days, even though the
authorization period is 60 days; however, the objective of the summary is to capture the client’s recent health problems and current health priorities. This section should not be merely a list of events. This section is the place to indicate the frequency of nursing interventions if they are different from the physician’s order on the POC, such as, the order may be for a procedure to be PRN (Pro Re Nata “As Needed”), but it is actually being performed every two hours.

- The addendum must include the rationale for increasing, decreasing, or maintaining the level of PDN and must relate to the client’s health problems and goals.
- The addendum must include the provider’s plan to decrease hours or discharge from service (if appropriate).

2.10.3.11.1 The client’s 24-Hour Daily Schedule

All direct-care services must be identified. It is understood that the schedule may change, as the client’s needs change. CCP does not have to be notified of changes in the schedule except as they occur when a PDN recertification is requested.

2.10.3.12 Responsible Adult or Identified Contingency Plan Requirement

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

- “Responsible adult” means an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.
- An identified contingency plan is a structured process, designed by the responsible adult and the PDN provider, by which a client will receive care when a scheduled private duty nurse is unexpectedly unavailable, and the responsible adult is unavailable, or is not trained, to provide the nursing care. The responsible adult must be able to initiate the identified contingency plan.

The responsible adult’s signature must be on the form acknowledging:

- Information about CCP PDN has been discussed and received.
- PDN may change or end based on a client’s need for nursing care.
- PDN is not authorized for the primary purpose of providing respite, childcare, ADLs, or housekeeping.
- All requirements have been met before seeking prior authorization for PDN.
- The responsible adult has participated in the development of the POC and the nursing care plan for the client.
- Emergency plans have been made and are part of the client’s care plan.
- The client or responsible adult agrees to follow the physician’s POC.

2.10.3.13 Special Circumstances

Prior authorization may be considered for PDN services provided in a school or day care facility, at the request of the family, provided the client requires the requested amount of PDN services in the home. Prior authorization may be considered for PDN services provided in a hospital, SN facility, or intermediate care facility for the mentally retarded, or special care facility with documentation from the facility showing it is unable to meet the SN needs of the client and the services are medically necessary. These facilities are required by licensure to meet all the medical needs of the client.
2.10.3.14 Documentation of Services Provided and Retrospective Review

Documentation elements that are routinely assessed for compliance in retrospective review of client records include, but are not limited to, the required documentation noted previously, as well as the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client’s name and Medicaid identification number.
- Client assessment time is documented at the beginning of each shift.
- All nurses’ arrival and departure times are documented with signature and time in the narrative section of the nurses’ notes.
- Entries in the nursing flowsheet or narrative notes must be dated and timed every 1 to 2 hours and must include the following:
  - The client’s condition.
  - The name of the medication, dose, route, time given, client response, and other pertinent information is recorded when medication is administered.
  - The name of treatment, time given, route or method used, client response, and other pertinent information is provided when treatments are administered.
  - The amount, type, times given, route or method used, client response, and other pertinent information is provided when feedings are administered.
  - The POC and documentation of services correlate with and reflect medical necessity for the services provided on any given day.
  - A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.
  - Client’s arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client.
  - Documentation of teaching the client or the client’s responsible adult includes the length of time, the subject of the teaching, the understanding of the subject matter by the person receiving the teaching, and other pertinent information.
  - Supervisory visits include specifics of the visit.
  - If a client is receiving SN services through another program or service in addition to CCP, such as MDCP, each provider’s shift notes designate specifically which type of service they are providing during that shift.

2.10.4 Claims Information

PDN providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. Home health agencies must submit claims on the UB-04 CMS-1450 paper claim form. Independently enrolled nurses must submit claims on the CMS-1500 paper claim form. TMHP does not supply the forms.

Refer to:
- Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.
- Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.
2.10.5 Reimbursement
PDN services are reimbursed in accordance with 1 TAC §355.8441.

2.11 Therapy Services (CCP)
Occupational therapist, physical therapist, and speech therapist services beyond the limitations of Texas Medicaid and Title XIX Home Health Services are benefits of the CCP for clients who are birth through 20 years of age and who are CCP eligible when:

- Therapy is prescribed by a licensed physician.
- Documentation of medical necessity supports a condition that requires ongoing therapy or rehabilitation in the usual course, treatment, and management of the client’s condition.
- Therapy services are provided by a licensed therapist.
- Therapy is provided in one of the following places of service:
  - CORF and ORF
  - Inpatient rehabilitation facility (freestanding)
  - Home
  - Licensed hospital
  - Medicaid-enrolled private therapist office
  - Physician office

This section does not apply to CORFs and ORFs.

Refer to: Subsection 2.4, “Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)” in this handbook.

Subsection 2.13, “Inpatient Rehabilitation Facility (Freestanding) (CCP)” in this handbook.

Therapy may be performed by a licensed occupational therapist, physical therapist, speech therapist, or one of the following under the supervision of a licensed therapist: licensed therapy assistant or licensed speech–language pathology intern.

Services performed by an OT aide, OT orderly, OT student, OT technician, PT aide, PT orderly, PT student, PT technician, SLP aide, SLP orderly, SLP student, or SLP technician are not a benefit of Texas Medicaid.

Therapy services performed by an unlicensed provider are subject to retrospective review and recoupment.

OT, PT, and ST may be performed in the office or home setting and may be authorized to be provided in the following locations: home of the client, home of the caregiver or guardian, client’s daycare facility, or the client’s school.

Services provided to a client on school premises are only permitted when delivered before or after school hours. The only CCP therapy services that can be delivered in the client’s school during regular school hours are those delivered by school districts as SHARS in POS 9.

Refer to: Section 3, “School Health and Related Services (SHARS)” in this handbook for more information about SHARS.
PT provided in the nursing home setting is limited to the nursing facility because it must be available to nursing home residents on an “as needed” basis and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside-qualified resources. Nursing home facilities must refrain from admitting clients who need goal directed therapy if the facility is unable to provide these services.

Home health agencies that perform therapy services under CCP are allowed one visit per day, per therapy type, and may be reimbursed at the statewide visit rate.

**Services That Are Not a Benefit**

The following services are not a benefit of CCP.

- Procedure code 97010 (application of a modality to one or more areas; hot or cold packs).
- Services that are not medically necessary. Examples include, but are not limited to:
  - Massage therapy that is the sole therapy or is not part of a therapeutic POC to address an acute condition.
  - Hippotherapy.
  - Separate reimbursement for VitalStim® therapy for dysphagia.
  - Treatment solely for the instruction of other agency or professional personnel in the client’s PT, OT, or ST program.
  - Training in nonessential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling).
  - Emotional support, adjustment to extended hospitalization or disability, and behavioral readjustment.
  - Therapy prescribed primarily as an adjunct to psychotherapy.

### 2.11.1 Occupational Therapy (OT)

#### 2.11.1.1 Enrollment

HHSC allows enrollment of independently-practicing licensed occupational therapist under CCP. The information in this section applies to CCP services only.

#### 2.11.1.2 Services, Benefits, and Limitations

A procedural modifier is required when submitting claims for occupational therapist services. Providers must use modifier GO for occupational therapist services. Procedural modifiers are not required for evaluations and re-evaluations.

Evaluations (procedure code 97003) are limited to once every 180 calendar days any provider. Re-evaluations (procedure code 97004) are limited once per 30 calendar days, any provider.

An evaluation or re-evaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

If a therapy evaluation or re-evaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied. OT evaluation (procedure code 97003) or re-evaluation (procedure code 97004) will be denied as part of the following OT procedure codes billed with Modifier GO.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012</td>
</tr>
<tr>
<td>97034</td>
</tr>
</tbody>
</table>
The following procedure codes are billed in 15-minute increments:

### Procedure Codes

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97140 97150 97530 97535 97537 97542 97750 97760 97761 97762</td>
</tr>
<tr>
<td>97799 S8990</td>
</tr>
</tbody>
</table>

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to two hours (eight units) per day individual, group, or a combination of individual and group therapy, per therapy type (two hrs. of OT and two hrs. of PT). Each 15 minutes equals one unit.

All 15-minute increment procedure codes are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units must be rounded up or down to the nearest quarter hour.

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

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not evenly divisible by 15, minutes greater than 7 are converted to 1 unit and 7 or fewer minutes are converted to 0 unit.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to 1 unit. Consequently, 68 total billable minutes = 5 units of service. The following table indicates the time intervals for 0 through 8 units:

### Units vs. Minutes

<table>
<thead>
<tr>
<th>Units</th>
<th>Number of Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 units</td>
<td>0 minutes through 7 minutes</td>
</tr>
<tr>
<td>1 unit</td>
<td>8 minutes through 22 minutes</td>
</tr>
<tr>
<td>2 units</td>
<td>23 minutes through 37 minutes</td>
</tr>
<tr>
<td>3 units</td>
<td>38 minutes through 52 minutes</td>
</tr>
<tr>
<td>4 units</td>
<td>53 minutes through 67 minutes</td>
</tr>
<tr>
<td>5 units</td>
<td>68 minutes through 82 minutes</td>
</tr>
<tr>
<td>6 units</td>
<td>83 minutes through 97 minutes</td>
</tr>
<tr>
<td>7 units</td>
<td>98 minutes through 112 minutes</td>
</tr>
<tr>
<td>8 units</td>
<td>113 minutes through 127 minutes</td>
</tr>
</tbody>
</table>

The following procedure codes are limited to once per day, for each therapy type (OT and PT):

### Procedure Codes

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012 97014 97016 97018 97022 97024 97026 97028 97150</td>
</tr>
</tbody>
</table>

Electrical stimulation therapy (procedure code 97032) may be considered with documentation of medical necessity.
2.11.1.3 Prior Authorization and Documentation Requirements

Prior authorization is required for OT except for therapy provided in the inpatient setting, evaluations or re-evaluations, services provided through the SHARS or Early Childhood Intervention (ECI) programs.

Refer to: Section 3, “School Health and Related Services (SHARS)” in this handbook for more information about SHARS.

Subsection 2.6, “Early Childhood Intervention (ECI) Services” in this handbook for more information about ECI.

The following documentation must be submitted to TMHP prior to the start of care for the current episode of therapy for consideration for prior authorization:

- A current written order by a physician based on medical necessity.
- A prescription is considered current when it is signed and dated, on or no later than, 60 days before the start of therapy.
- A “Request for Initial Outpatient Therapy (Form TP-1)” or “Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)” must be submitted to TMHP prior to the start of care for the current episode of therapy.
- The most recent evaluation and treatment plan. To establish medical necessity, the written treatment plan must include the following:
  - The age of the client at the time of evaluation.
  - Diagnosis.
  - Description of specific therapy being prescribed.
  - Specific treatment goals related to the client’s individual needs. Therapy goals may include improving function, maintenance of function, or slowing of the deterioration of function.
  - For an initial request, anticipated measurable progress toward goals, the prognosis, and the client’s gross motor skills in years or months.
  - For a new request for additional therapy, documentation of all progress made from the beginning of the previous treatment period.
  - Duration and frequency of therapy.
  - Requested date of service.

The number of sessions per week must be supported by documentation supporting the medical necessity for the frequency requested.

When requesting prior authorization for group OT, the provider must submit documentation supporting the group process as being medically necessary and beneficial to the client. When group therapy is authorized, weekly therapy limits will not be exceeded.

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on behalf of the client’s physician when the physician delegates this authority.

A request for occupational therapist services may be prior authorized for no longer than 180 days duration. A new request must be submitted if therapy is required for a longer duration. A physician’s prescription is required every 180 days.

The GO modifier is required on all prior authorization requests for OT.
If a provider discontinues therapy with a client and a new provider begins therapy during an existing authorization period, submission of a new plan of care and documentation of the last therapy visit with the previous provider is required along with a letter from the client, or responsible adult, stating the date therapy ended with the previous provider.

2.11.1.4 Claims Information

Providers must submit claims for therapy services in an approved electronic claims format, a CMS-1500, or UB-04 CMS-1450 paper claim form 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.

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


2.11.1.5 Reimbursement

Occupational therapist services are reimbursed in accordance with 1 TAC §355.8441. See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

2.11.2 Physical Therapy (PT)

2.11.2.1 Enrollment

HHSC allows enrollment of independently-practicing licensed physical therapist under CCP. The information in this section applies to CCP services only.

2.11.2.2 Services, Benefits, and Limitations

A procedural modifier is required when submitting claims for physical therapist services. Providers must use modifier GP for physical therapist services. Procedural modifiers are not required for evaluations and re-evaluations.

Evaluations (procedure code 97001) are limited to once every 180 calendar days any provider. Re-evaluations (procedure code 97002) are limited once per 30 calendar days, any provider.

An evaluation or re-evaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

If a therapy evaluation or re-evaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied. PT evaluation (procedure code 97001) or re-evaluation (procedure code 97002) will be denied as part of the following PT procedure codes billed with Modifier GP.

| Procedure Codes | 97012 | 97014 | 97016 | 97018 | 97020 | 97022 | 97024 | 97026 | 97028 | 97032 | 97034 | 97035 | 97036 | 97037 | 97038 | 97040 | 97043 | 97046 | 97048 | 97050 | 97052 | 97054 | 97056 |
|----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Procedure Codes | 97012 | 97014 | 97016 | 97018 | 97020 | 97022 | 97024 | 97026 | 97028 | 97032 | 97034 | 97035 | 97036 | 97037 | 97038 | 97040 | 97043 | 97046 | 97048 | 97050 | 97052 | 97054 | 97056 |
| Procedure Codes | 97012 | 97014 | 97016 | 97018 | 97020 | 97022 | 97024 | 97026 | 97028 | 97032 | 97034 | 97035 | 97036 | 97037 | 97038 | 97040 | 97043 | 97046 | 97048 | 97050 | 97052 | 97054 | 97056 |
| Procedure Codes | 97012 | 97014 | 97016 | 97018 | 97020 | 97022 | 97024 | 97026 | 97028 | 97032 | 97034 | 97035 | 97036 | 97037 | 97038 | 97040 | 97043 | 97046 | 97048 | 97050 | 97052 | 97054 | 97056 |
| Procedure Codes | 97012 | 97014 | 97016 | 97018 | 97020 | 97022 | 97024 | 97026 | 97028 | 97032 | 97034 | 97035 | 97036 | 97037 | 97038 | 97040 | 97043 | 97046 | 97048 | 97050 | 97052 | 97054 | 97056 |
| Procedure Codes | 97012 | 97014 | 97016 | 97018 | 97020 | 97022 | 97024 | 97026 | 97028 | 97032 | 97034 | 97035 | 97036 | 97037 | 97038 | 97040 | 97043 | 97046 | 97048 | 97050 | 97052 | 97054 | 97056 |
The following procedure codes are billed in 15-minute increments:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97032</td>
</tr>
<tr>
<td>97034</td>
</tr>
<tr>
<td>97036</td>
</tr>
<tr>
<td>97110</td>
</tr>
<tr>
<td>97113</td>
</tr>
<tr>
<td>97124</td>
</tr>
<tr>
<td>97140</td>
</tr>
<tr>
<td>97535</td>
</tr>
<tr>
<td>97542</td>
</tr>
<tr>
<td>97760</td>
</tr>
<tr>
<td>97762</td>
</tr>
<tr>
<td>S8990</td>
</tr>
</tbody>
</table>

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to two hours (eight units) per day individual, group, or a combination of individual and group therapy, per therapy type (two hrs of OT and two hrs of PT). Each 15 minutes equals one unit.

All 15-minute increment procedure codes are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units must be rounded up or down to the nearest quarter hour.

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

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not evenly divisible by 15, minutes greater than 7 are converted to 1 unit and 7 or fewer minutes are converted to 0 unit.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to 1 unit. Consequently, 68 total billable minutes = 5 units of service.

Refer to: Subsection 2.11.1, “Occupational Therapy (OT)” in this handbook for 15-minute conversion table.

The following procedure codes are limited to once per day, for each therapy type (OT and PT):

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012</td>
</tr>
<tr>
<td>97016</td>
</tr>
<tr>
<td>97022</td>
</tr>
<tr>
<td>97026</td>
</tr>
<tr>
<td>97150</td>
</tr>
</tbody>
</table>

Electrical stimulation therapy (procedure code 97032) may be considered with documentation of medical necessity.

2.11.2.3 Prior Authorization and Documentation Requirements

Prior authorization is required for PT except for therapy provided in the inpatient setting, evaluations or re-evaluations, services provided through the SHARS or ECI programs.

Refer to: Section 3, “School Health and Related Services (SHARS)” in this handbook for more information about SHARS.

Subsection 2.6, “Early Childhood Intervention (ECI) Services” in this handbook for more information about ECI.

The following documentation must be submitted to TMHP prior to the start of care for the current episode of therapy for consideration for prior authorization:

- A current written order by a physician and based on medical necessity.
- A prescription is considered current when it is signed and dated on, or no later than, 60 days before the start of therapy.
- A “Request for Initial Outpatient Therapy (Form TP-1)” or “Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)” must be submitted to TMHP prior to the start of care for the current episode of therapy.
The most recent evaluation and treatment plan. To establish medical necessity, the written treatment plan must include the following:

- The age of the client at the time of evaluation
- Diagnosis
- Description of specific therapy being prescribed
- Specific treatment goals related to the client’s individual needs. Therapy goals may include improving function, maintenance of function, or slowing of the deterioration of function.
- For an initial request, anticipated measurable progress toward goals, the prognosis, and the client’s gross motor skills in years or months.
- For a new request for additional therapy, documentation of all progress made from the beginning of the previous treatment period.
- Duration and frequency of therapy
- Requested date of service

The number of sessions per week must be supported by documentation supporting the medical necessity of the frequency requested.

When requesting prior authorization for group PT, the provider must submit documentation supporting the group process as being medically necessary and beneficial to the client. When group therapy is authorized, weekly therapy limits will not be exceeded.

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on behalf of the client’s physician when the physician delegates this authority.

A request for physical therapist services may be prior authorized for no longer than 180 days duration. A new request must be submitted if therapy is required for a longer duration. A physician’s prescription is required every 180 days.

The GP modifier is required on all prior authorization requests for PT.

If a provider discontinues therapy with a client and a new provider begins therapy during an existing authorization period, submission of a new plan of care and documentation of the last therapy visit with the previous provider is required along with a letter from the client, or responsible adult stating the date therapy ended with the previous provider.

2.11.2.4 Claims Information

Providers must submit claims for therapy services in an approved electronic claims format, a CMS-1500, or UB-04 CMS-1450 paper claim form 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.


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.

2.11.2.5 Reimbursement

Physical therapist services are reimbursed in accordance with 1 TAC §355.8441.
See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

2.11.3 Speech Therapy (ST)

2.11.3.1 Enrollment

HHSC allows enrollment of independently-practicing licensed SLPs under CCP. The information in this section applies to CCP services only.

2.11.3.2 Services, Benefits, and Limitations

A procedural modifier is required when submitting claims for ST services. Providers must use modifier GN for ST services. Procedural modifiers are not required for evaluations and re-evaluations.

ST evaluation (procedure code 92506) is limited to once every 180 calendar days, any provider. ST re-evaluation (procedure code S9152) is limited to once every 30 calendar days, any provider.

ST treatment codes 92507, 92508, and 92526 are payable in 15-minute increments at a maximum of four units (one hour) per day.

All 15-minute increment procedure codes are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units must be rounded up or down to the nearest quarter hour.

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

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not evenly divisible by 15, minutes greater than 7 are converted to 1 unit and 7 or fewer minutes are converted to 0 unit.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to 1 unit. Consequently, 68 total billable minutes = 5 units of service.

Refer to: Subsection 2.11.1, “Occupational Therapy (OT)” in this handbook for the 15-minute conversion table.

ST evaluation and re-evaluations will be denied when billed on the same date of service, any provider, as procedure codes 92507 and 92508 with modifier GN.

Procedure codes 92526 and 92610 may be considered for reimbursement for treatment and evaluation of swallowing dysfunctions and oral functions for feeding.

Procedure code 97535 is used for ST services for training for augmentative communication devices.

2.11.3.3 Prior Authorization and Documentation Requirements

Prior authorization is required for ST except for therapy provided in the inpatient setting, evaluations or re-evaluations, or services provided through the SHARS or ECI programs.

Refer to: Section 3, “School Health and Related Services (SHARS)” in this handbook for more information about SHARS.

Subsection 2.6, “Early Childhood Intervention (ECI) Services” in this handbook for more information about ECI.

The following documentation must be submitted to TMHP prior to the start of care for the current episode of therapy for consideration for prior authorization:

• A current written order by a physician and based on medical necessity.
A prescription is considered current when it is signed and dated on or no later than 60 days before the start of therapy.

A “Request for Initial Outpatient Therapy (Form TP-1)” or “Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)” must be submitted to TMHP prior to the start of care for the current episode of therapy.

The most recent evaluation and treatment plan. To establish medical necessity, the written treatment plan must include the following:

- The age of the client at the time of evaluation.
- Diagnosis.
- Description of specific therapy being prescribed.
- Specific treatment goals related to the client’s individual needs. Therapy goals may include improving function, maintenance of function, or slowing of the deterioration of function.
- For an initial request, anticipated measurable progress toward goals, the prognosis, and the client’s gross motor skills in years or months.
- For a new request for additional therapy, documentation of all progress made from the beginning of the previous treatment period.
- Duration and frequency of therapy.
- Requested date of service.

The number of sessions per week must be supported by documentation supporting the medical necessity for the frequency requested.

When requesting prior authorization for group ST, the provider must submit documentation supporting the group process as being medically necessary and beneficial to the client. When group therapy is authorized, weekly therapy limits will not be exceeded.

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on behalf of the client’s physician when the physician delegates this authority.

A request for ST services may be prior authorized for no longer than 180 days duration. A new request must be submitted if therapy is required for a longer duration. A physician’s prescription is required every 180 days.

The GN modifier is required on all prior authorization requests for ST.

If a provider discontinues therapy with a client and a new provider begins therapy during an existing authorization period, submission of a new plan of care and documentation of the last therapy visit with the previous provider is required along with a letter from the client, or responsible adult, stating the date therapy ended with the previous provider.

2.11.3.4 Claims Information

Providers must submit claims for therapy services in an approved electronic claims format, a CMS-1500, or UB-04 CMS-1450 paper claim form 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.

2.11.3.5 **Reimbursement**

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

See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

**2.12 Inpatient Psychiatric Hospital or Facility (Freestanding) (CCP)**

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 birth through 20 years of age at the time of the service request and service delivery, if the client meets certain conditions.


**2.13 Inpatient Rehabilitation Facility (Freestanding) (CCP)**

**2.13.1 Enrollment**

Note: Rehabilitation provided at an acute care facility is covered through Texas Medicaid fee-for-service.

To be eligible to participate in CCP, a freestanding inpatient rehabilitation facility must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Texas Medicaid enrolls and reimburses freestanding inpatient rehabilitation facilities for CCP services and Medicare deductibles or coinsurance according to current payment guidelines. The information in this section is applicable to CCP services only.

Refer to: Subsection 2.1.2, “Enrollment” in this handbook for more information about CCP enrollment procedures.

**2.13.1.1 Continuity of Hospital Eligibility Through Change of Ownership**

Under procedures set forth by the CMS and HHSC, a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued subject to the following requirements:

- The provider must obtain recertification as a Title XVIII (Medicare) hospital.
- The hospital under new ownership must submit a new signed and dated HHSC Medicaid Provider Agreement between the hospital and HHSC.

Providers can download the HHSC Medicaid Provider Agreement from the TMHP website at www.tmhp.com.

**2.13.2 Services, Benefits, and Limitations**

Inpatient rehabilitation 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. Inpatient rehabilitation services will be considered for an acute problem or an acute exacerbation of a chronic problem resulting in a significant decrease in functional ability that will benefit from inpatient rehabilitation services. A condition is considered to be acute or an acute exacerbation of a chronic condition only during the six months from the onset date of the acute condition or the acute exacerbation of the chronic condition.
2.13.2.1 Comprehensive Treatment

The intensity of necessary rehabilitative service cannot be provided in the outpatient setting.

Comprehensive rehabilitation treatment must be under the leadership of a physician. Comprehensive rehabilitation treatment must be an active interdisciplinary team, defined as at least two types of therapies.

Comprehensive treatment must consist of at least two appropriate physical modalities designed to resolve or improve the client's condition (OT, PT, and ST), and must be provided for a minimum of three hours per day for five days per week.

2.13.3 Prior Authorization and Documentation Requirements

All inpatient rehabilitation services provided to clients who are birth through 20 years of age in a freestanding inpatient rehabilitation facility require prior authorization.

Prior authorization will be considered when the client has met all of the following criteria:

- The client has an acute problem or an acute exacerbation of a chronic problem resulting in a significant decrease in functional ability that will benefit from inpatient rehabilitation services.
- The intensity of necessary rehabilitative service cannot be provided in the outpatient setting.
- The client requires and will receive multidisciplinary team care defined as at least two therapies (OT, PT, or ST).
- This therapy will be provided for a minimum of three hours per day, five days per week.

The physician and the provider must maintain all documentation in the client’s medical record.

Inpatient rehabilitation may be prior authorized for up to two months when the attending physician submits documentation of medical necessity. The treatment plan must indicate that the client is expected to improve within a 60-day period and be restored to a more functional lifestyle for an acute condition or the previous level of function for an acute exacerbation of a chronic condition.

Requests for subsequent services for increments up to 60 days may be prior authorized based on medical necessity. Requests for prior authorization of subsequent services must be received before the end-date of the preceding prior authorization.

A prior authorization request for an additional 60 days of therapy will be considered with documentation supporting medical necessity.

Supporting documentation for an initial request must include the following:

- A signed physician’s order including the physician’s original handwritten signature (stamped signatures and dates are not accepted). The physician’s signature is valid for no more than 90 days prior to the requested start of care date.
- A CCP Prior Authorization Form signed and dated by the physician.
- A current therapy evaluation with the documented age of the client at the time of evaluation.
- Therapy goals related to the client’s individual needs; goals may include improving or maintaining function, or slowing of deterioration of function.
- An updated written comprehensive treatment plan established by the attending physician or by the therapist to be followed during the inpatient rehabilitation admission that:
  - Is under the leadership of a physician and includes a description of the specific therapy being prescribed, diagnosis, treatment goals related to the client’s individual needs, and duration and frequency of therapy.
  - Includes the date of onset of the illness or injury requiring the freestanding inpatient rehabilitation facility admission.
• Includes the requested dates of service.

• Incorporates an active interdisciplinary team.

• Consists of at least two appropriate physical modalities (OT, PT, and ST) designed to resolve or improve the client’s condition.

• Includes a minimum of three hours of team interaction with the client every day, five days per week.

• In addition to the documentation for an initial request, supporting documentation for a request for subsequent services must include the following:

  • A brief synopsis of the outcomes of the previous treatment relative to the debilitating condition.

  • The expected results to be achieved by an extension of the active treatment plan, and the time interval at which this extension outcome should be achieved.

  • Discussion why the initial two months of inpatient rehabilitation has not met the client’s needs and why the client cannot be treated in an outpatient setting.

After receiving the documentation establishing the medical necessity and plan of medical care by the treating physician, prior authorization is considered by CCP for the initial service and an extension of service as applicable. A request for prior authorization must include documentation from the provider to support the medical necessity of the service.

2.13.4 Claims Information

Providers must submit inpatient rehabilitation services to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form. Providers must purchase the UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

For OT, PT, and ST services, freestanding inpatient rehabilitation facilities and acute care hospitals can use revenue codes 128, 420, 424, 430, 434, 440, and 444.

TMHP must receive claims for payment consideration according to filing deadlines for inpatient claims. Claims for services that have been prior authorized must reflect the PAN in Block 63 of the UB-04 CMS-1450 paper claim form or its electronic equivalent.

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

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


Form CH.26, “Inpatient Rehabilitation Facility (Freestanding) (CCP Only)” in this handbook for a claim form example.

2.13.5 Reimbursement

Reimbursement for care provided in the freestanding inpatient rehabilitation facility is made under the Texas Diagnosis-Related Group (DRG) Payment System.

A new provider is given a reimbursement interim rate of 50 percent until a cost audit has been performed. Payment is calculated by multiplying the standard dollar amount (SDA) for the hospital’s payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Important: Outpatient services are not reimbursed.
The DRG payment may be enhanced by an adjusted day or cost outlier payment, if applicable. For example, the limit per spell-of-illness under Texas Medicaid guidelines is waived for clients who are birth through 20 years of age. An outlier payment may be made to compensate for unusual resource utilization or a lengthy stay.

The following criteria must be met to qualify for a day outlier payment. Inpatient days must exceed the DRG day threshold for the specific DRG. Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 70 percent of the per diem amount of a full DRG payment. The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

To establish a cost outlier, TMHP determines the outlier threshold by using the greater of the full DRG payment amount multiplied by 1.5 or an amount determined by selecting the lesser of the universe mean of the current base year data multiplied by 11.14 or the hospital’s SDA multiplied by 11.14. The calculation that yields the greater amount is used in calculating the actual cost outlier payment. The outlier threshold is subtracted from the amount of reimbursement for the admission established under the TEFRA principles and the remainder multiplied by 70 percent to determine the actual amount of the cost outlier payment.

If an admission qualifies for both a day and a cost outlier, the outlier resulting in the highest payment to the hospital is paid.

The Remittance and Status (R&S) Report reflects the outlier reimbursement payment and defines the type of outlier paid, day or cost.

Providers should call the TMHP provider relations representative for their area with questions about the outlier payment.

**2.13.5.1 Client Transfers**

When more than one hospital provides care for the same case, the hospital furnishing the most significant amount of care receives consideration for a full DRG payment.

The other hospital(s) is/are paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility. The DRG modifier PT on the R&S Report indicates per diem pricing related to a client transfer.

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. The facility must bill only one claim.

After all hospital claims have been submitted, HHSC performs a post-payment review to determine whether the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.
3. SCHOOL HEALTH AND RELATED SERVICES (SHARS)

3.1 Overview
Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as SHARS. The oversight of SHARS is a cooperative effort between the Texas Education Agency (TEA) and HHSC. SHARS allows local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services provided to students in special education under IDEA that are documented in a student’s Individualized Education Program (IEP).

**Important:** CMS requires school districts to be enrolled as a SHARS Medicaid provider, participate in the Random Moment Time Study (RMTS), claim on an interim basis, and submit an annual SHARS Cost Report.

SHARS reimbursement is provided for students who meet all of the following requirements:
- Are 20 years of age and younger and eligible for Medicaid
- Meet eligibility requirements for special education described in IDEA
- Have IEPs that prescribe the needed services

Services covered by SHARS includes:
- Audiology services
- Counseling
- Nursing services
- Occupational therapy (OT)
- Personal care services (PCS)
- Physical therapy (PT)
- Physician services
- Psychological services, including assessments
- Speech therapy (ST)
- Transportation in a school setting

These services must be provided by qualified personnel who are under contract with or employed by the school district.

3.1.1 Random Moment Time Study (RMTS)
CMS requires SHARS providers to participate in the RMTS to be eligible to submit claims and receive reimbursement for SHARS services. SHARS providers must comply with the Texas Time Study Guide, which includes, but is not limited to, Mandatory Annual RMTS Contact training certification of RMTS participants for all three annual RMTS quarters, and compliance with participation requirements for selected sampled moments. The three annual RMTS quarters are October through December, January through March, and April through June. A July through September RMTS is not conducted.

An existing school district can only become a SHARS provider effective October 1, each year and they must participate in all three RMTS quarters for that annual period. SHARS providers that do not participate in all three required RMTS quarters, or are RMTS non-compliant, cannot be a SHARS provider for that entire annual period (October 1 through September 30) and will be required to return any Medicaid payments received for SHARS services delivered during that annual cost report period. The school district can return to participating in the SHARS program the following federal fiscal year beginning on October 1.
A new school district (i.e., a newly formed district that began operations after October 1) can become a SHARS provider effective with the first day of the federal quarter in which it participates in the RMTS. New SHARS providers may not submit claims or be reimbursed for SHARS services provided prior to the RMTS quarter in which they begin to participate and they must participate in all remaining RMTS quarters for that annual period.

School districts can access the Texas Time Study Guide, on the HHSC website at www.hhsc.state.tx.us/rad/time-study/ts-isd.shtml and refer to the link titled Guides/Manuals.

SHARS providers can contact the HHSC Time Study Unit via email at TimeStudy@hhsc.state.tx.us or by telephone at (512) 491-1715.

3.1.2 Eligibility Verification
The following are means to verify Medicaid eligibility of students:

- Verify electronically through third party software or TexMedConnect.
- School districts may inquire about the eligibility of a student by submitting the student’s Medicaid number or two of the following: name, date of birth, or Social Security number (SSN). A search can be narrowed further by entering the county code or sex of the student. Verifications may be submitted in batches without limitations on the number of students.
- Contact AIS at 1-800-925-9126.

3.2 Enrollment

3.2.1 SHARS Enrollment
To enroll in Texas Medicaid as a SHARS provider, school districts, including public charter schools, must employ or contract with individuals or entities that meet certification and licensing requirements in accordance with the Texas Medicaid State Plan for SHARS to provide program services. Since public school districts are government entities, they should select “public entity” on the enrollment application.

SHARS providers are required to notify parents or guardians of their rights to a “freedom of choice of providers” (42 CFR §431.51) under Texas Medicaid. Most SHARS providers currently provide this notification during the initial Admission, Review, and Dismissal (ARD) process. If a parent requests that someone other than the employees or currently contracted staff of the SHARS provider (school district) provide a required service listed in the student’s IEP, the SHARS provider must make a good faith effort to comply with the parent’s request. The SHARS provider can negotiate with the requested provider to provide the services under contract. The requested provider must meet, comply with, and provide all of the employment criteria and documentation that the SHARS provider normally requires of its employees and currently contracted staff. The SHARS provider can negotiate the contracted fee with the requested provider and is not required to pay the same fee that the requested provider might receive from Medicaid for similar services.

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.

3.2.2 Private School Enrollment
A private school may not participate in the SHARS program as a SHARS provider.
3.3 Services, Benefits, Limitations, and Prior Authorization

All of the SHARS procedures listed in the following sections require a valid International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code. SHARS includes audiology services, counseling, physician services, nursing services, psychological services, OT, PT, or ST services, personal care services, and transportation.

**Reminder:** SHARS are the services determined by the ARD committee to be medically necessary and reasonable to ensure that children with disabilities who are eligible for Medicaid and who are 20 years of age and younger receive the benefits accorded to them by federal and state law in order to participate in the educational program.

3.3.1 Audiology

Audiology evaluation services include:

- Identification of children with hearing loss
- Determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for the habilitation of hearing
- Determination of the child’s need for group and individual amplification

Audiology therapy services include the provision of habilitation activities, such as language habilitation, auditory training, audiological maintenance, speech reading (lip reading), and speech conversation.

Audiology services must be provided by a professional who holds a valid state license as an audiologist or by an audiology assistant who is licensed by the state when the assistant is acting under the supervision of a qualified audiologist. State licensure requirements are equal to American Speech-Language-Hearing Association (ASHA) certification requirements.

Audiology evaluation is billable on an individual (procedure code 92506) basis only. Audiology therapy is billable on an individual (procedure code 92507) and group (procedure code 92508) basis.

Only the time spent with the student present is billable; time spent without the student present is not billable.

Session notes for evaluations are not required; however, documentation must include the billable start time, billable stop time, and total billable minutes with a notation of the activity performed (e.g., audiology evaluation).

Session notes are required for therapy. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

3.3.1.1 Audiology Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Therapist or Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>92506 with modifier U9</td>
<td>Individual</td>
<td>Licensed audiologist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92507 with modifier U9</td>
<td>Individual</td>
<td>Licensed audiologist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92507 with modifier U1</td>
<td>Individual</td>
<td>Licensed/certified assistant</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92508 with modifier U9</td>
<td>Group</td>
<td>Licensed audiologist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92508 with modifier U1</td>
<td>Group</td>
<td>Licensed/certified assistant</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.
The recommended maximum billable time for audiology evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct audiology therapy (individual or group) is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.2 Counseling Services

Counseling services are provided to help a child with a disability benefit from special education and must be listed in the IEP. Counseling services include, but are not limited to, the following:

- Assisting the child or parents in understanding the nature of the child’s disability
- Assisting the child or parents in understanding the special needs of the child
- Assisting the child or parents in understanding the child’s development
- Health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors that are important to the prevention, treatment, or management of physical health problems
- Assessing the need for specific counseling services

Counseling services must be provided by a professional who has one of the following certifications or licensures: a licensed professional counselor (LPC), a licensed clinical social worker (LCSW), or a licensed marriage and family therapist (LMFT).

Counseling services are billable on an individual (procedure code 96152) or group (procedure code 96153) basis. Session notes are required and documentation must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency counseling services as long as the student’s IEP includes a behavior improvement plan that documents the need for emergency services.

3.3.2.1 Counseling Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>96152 with modifier UB</td>
<td>Individual</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>96153 with modifier UB</td>
<td>Group</td>
</tr>
</tbody>
</table>

*Place of Service: 1 = Office; 2 = Home; 9 = Other Locations

Providers must use a 15-minute unit of service for billing.

The recommended maximum billable time (individual or group) is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.3 Psychological Testing and Services

3.3.3.1 Psychological Testing

Evaluations or assessments include activities related to the evaluation of the functioning of a student for the purpose of determining eligibility, the needs for specific SHARS services, and the development or revision of IEP goals and objectives. An evaluation or assessment is billable if it leads to the creation of an IEP for a student with disabilities who is eligible for Medicaid and who is 20 years of age or younger, whether or not the IEP includes SHARS.
Evaluations or assessments (procedure code 96101) must be provided by a professional who is a licensed specialist in school psychology (LSSP), a licensed psychologist, or a licensed psychiatrist in accordance with 19 TAC §89.1040(b)(1) and 34 CFR §300.136(a)(1).

Evaluation or assessment billable time includes the following:

- Psychological, educational, or intellectual testing time spent with the student present
- Necessary observation of the student associated with testing
- A parent/teacher consultation with the student present that is required during the assessment because a student is unable to communicate or perform certain activities
- Time spent without the student present for the interpretation of testing results
- Report writing

Time spent gathering information without the student present or observing a student is not billable evaluation or assessment time.

Session notes are not required; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note which assessment activity was performed (e.g., testing, interpretation, or report writing).

### 3.3.3.1.1 Evaluation or Assessment Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual/Group</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>96101</td>
<td>Individual</td>
<td>1 hour</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

**Important:** One unit (1.0) is equivalent to one hour or 60 minutes. Providers may bill in partial hours, expressed as 1/10th of an hour (six-minute segments). For example, express 30 minutes as a billed quantity of 0.5.

**Refer to:** Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

When billing, minutes of Evaluations or Assessments are not accumulated over multiple days. Minutes of Evaluations or Assessments can only be billed per calendar day.

The recommended maximum billable time for psychological testing is eight hours (8.0 units) over a 30-day period. Time spent for the interpretation of testing results without the student present is billable time. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### 3.3.3.2 Psychological Services

Psychological services are counseling services provided to help a child with a disability benefit from special education and must be listed in the IEP.

Psychological services must be provided by a licensed psychiatrist, a licensed psychologist, or an LSSP. Nothing in this rule prohibits public schools from contracting with licensed psychologists, licensed psychological associates, and provisionally licensed psychologists who are not LSSPs to provide psychological services, other than school psychology, in their areas of competency. School districts may contract for specific types of psychological services, such as clinical psychology, counseling psychology, neuropsychology, and family therapy, that are not readily available from the LSSP who is employed by the school district. Such contracting must be on a short-term or part-time basis and cannot involve the broad range of school psychological services listed in 22 TAC §465.38(1)(B).

All psychological services are billable on an individual (procedure code 96152) or group (procedure code 96153) basis.
Session notes are required. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency psychological services as long as the student’s IEP includes a behavior improvement plan that documents the need for the emergency services.

3.3.3.2.1 Psychological Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>96152 with modifier AH</td>
<td>Individual</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>96153 with modifier AH</td>
<td>Group</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for direct psychological therapy (individual or group) is a total of one hour per day for nonemergency situations. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.4 Nursing Services

Nursing services are SN tasks, as defined by the Texas BON, that are included in the student’s IEP. Nursing services may be direct nursing care or medication administration. Examples of reimbursable nursing services include, but are not limited to, the following:

- Inhalation therapy
- Ventilator monitoring
- Nonroutine medication administration
- Tracheostomy care
- Gastrostomy care
- Ileostomy care
- Catheterization
- Tube feeding
- Suctioning
- Client training
- Assessment of a student’s nursing and personal care services needs

Direct nursing care services are billed in 15-minute increments and medication administration is reimbursed on a per-visit increment. The RN or APRN determines whether these services must be billed as direct nursing care or medication administration.

Nursing services must be provided by an RN, an APRN (including NPs and CNSs), LVN, LPN, or a school health aide or other trained, unlicensed assistive person delegated by an RN or APRN.

Nursing services are billable on an individual or group basis. Only the time spent with the student present is billable. Time spent without the student present is not billable. Session notes are not required for nursing services; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of nursing service that was performed.
3.3.4.1 Nursing Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>T1002 with modifier TD</td>
<td>Individual</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1002 with modifier TD and UD</td>
<td>Group</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1502 with modifier TD</td>
<td>Medication administration, per visit</td>
<td></td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1002 with modifier U7</td>
<td>Delegation, Individual</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1002 with modifier U7 and UD</td>
<td>Delegation, group</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1502 with modifier U7</td>
<td>Delegation, medication administration, per visit</td>
<td></td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1003 with modifier TE</td>
<td>Individual</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1003 with modifier TE and UD</td>
<td>Group</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1502 with modifier TE</td>
<td>Medication, administration per visit</td>
<td></td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations
Modifier TD = nursing services provided by an RN or APRN
Modifier U7 = nursing services delivered through delegation
Modifier TE = nursing services delivered by an LVN/LPN
Modifier UD = nursing services delivered on a group basis

The Medicaid-allowable fee is determined based on 15-minute increments. Providers must use a 15-minute unit of service for billing.

All of the nursing services minutes that are delivered to a student during a calendar day must be added together before they are converted to units of service. Do not convert minutes of nursing services separately for each nursing task that was performed.

Minutes of nursing services cannot be accumulated over multiple days. Minutes of nursing services can only be billed per calendar day. If the total number of minutes of nursing services is less than eight minutes for a calendar day, then no unit of service can be billed for that day, and that day’s minutes cannot be added to minutes of nursing services from any previous or subsequent days for billing purposes.

Refer to: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for direct nursing services is four hours per day. The recommended maximum billable units for procedure code T1502 with modifier TD, T1502 with modifier U7, or T1502 with modifier TE is a total of four medication administration visits per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.5 Occupational Therapy (OT)

3.3.5.1 Referral

In order for a student to receive OT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribed the OT must be provided.
3.3.5.2 Description of Services

OT evaluation services include determining what services, assistive technology, and environmental modifications a student requires for participation in the special education program.

OT includes:

- Improving, developing, maintaining, or restoring functions impaired or lost through illness, injury, or deprivation.
- Improving the ability to perform tasks for independent functioning when functions are impaired or lost.
- Preventing, through early intervention, initial or further impairment or loss of function.

OT must be provided by a professional who is licensed by the Texas Board of Occupational Therapy Examiners or a COTA acting under the supervision of a qualified occupational therapist.

OT evaluation is billable on an individual (procedure code 97003) basis only. OT is billable on an individual (procedure code 97530) or group (procedure code 97150) basis.

The occupational therapist or COTA can only bill for time spent with the student present, including time spent assisting the student with learning to use adaptive equipment and assistive technology.

Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time), report writing, and time spent manipulating or modifying the adaptive equipment is not billable.

Session notes are not required for procedure code 97003; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., OT evaluation).

Session notes are required for procedure codes 97530 and 97150. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

3.3.5.3 Occupational Therapy Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Therapist or Licensed/Certified Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>97003</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97150 with modifier GO</td>
<td>Group</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97150 with modifier GO and U1</td>
<td>Group</td>
<td>Licensed/certified assistant</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97530 with modifier GO</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97530 with modifier GO and U1</td>
<td>Individual</td>
<td>Licensed/certified assistant</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for OT evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (individual or group) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.
3.3.6 Personal Care Services

Personal care services are provided to help a child with a disability or chronic condition benefit from special education. Personal care services include a range of human assistance provided to persons with disabilities or chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a functional, cognitive, or behavioral impairment.

Refer to: Subsection 2.9, “Personal Care Services (PCS) (CCP)” in this handbook for a list of ADLs and IADLs.

For personal care services to be billable, they must be listed in the student’s IEP. Personal care services are billable on an individual (procedure code T1019 with modifier U5 or U6) or group (procedure code T1019 with modifier U5 and UD or U6 and UD) basis.

Session notes are not required for procedure codes T1019 with modifier U5 or T1019 with modifier U5 and UD; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of personal care service that was performed.

Procedure codes T1019 with modifier U6 and T1019 with modifier U6 and UD are billed using a one-way trip unit of service.

3.3.6.1 Personal Care Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U5</td>
<td>Individual, school</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U5 and UD</td>
<td>Group, school</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U6</td>
<td>Individual, bus</td>
<td>Per one-way trip</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U6 and UD</td>
<td>Group, bus</td>
<td>Per one-way trip</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

Refer to: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable units for T1019 with modifier U6 or T1019 with modifier U6 and UD is a total of four one-way trips per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended units of service are billed.

3.3.7 Physical Therapy (PT)

3.3.7.1 Referral

In order for a student to receive PT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribes the PT must be provided.

3.3.7.2 Description of Services

PT evaluation includes evaluating the student’s ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems.

PT is provided for the purpose of preventing or alleviating movement dysfunction and related functional problems.

PT must be provided by a professional who is licensed by the Texas Board of Physical Therapy Examiners or a licensed physical therapist assistant (LPTA) acting under the supervision of a qualified physical therapist.
PT evaluation is billable on an individual (procedure code 97001) basis only. PT is billable on an individual (procedure code 97110) or group (procedure code 97150) basis.

The physical therapist can only bill time spent with the student present, including time spent helping the student to use adaptive equipment and assistive technology.

Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time) and report writing, is not billable.

Session notes are not required for procedure code 97001; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., PT evaluation). Session notes are required for procedure codes 97110 and 97150.

Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

### 3.3.7.3 Physical Therapy Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Therapist or Licensed/Certified Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>97001</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97110 with modifier GP</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97110 with modifier GP and U1</td>
<td>Individual</td>
<td>Licensed or certified assistant</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97150 with modifier GP</td>
<td>Group</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97150 with modifier GP and U1</td>
<td>Group</td>
<td>Licensed or certified assistant</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for PT evaluation is three hours, which may be billed within a 30 day period. The recommended maximum billable time for direct therapy (individual or group) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### 3.3.8 Physician Services

Diagnostic and evaluation services are reimbursable under SHARS physician services. Physician services must be provided by a licensed physician (M.D. or D.O.). A physician prescription is required before PT or OT services may be reimbursed under SHARS. ST services require either a physician prescription or a referral from a licensed SLP before the ST services may be reimbursed under the SHARS program. The school district must maintain the prescription or referral. The prescription or referral must relate directly to specific services listed in the IEP. If a change is made to a service on the IEP that requires a prescription or referral, the prescription or referral must be revised accordingly.

The expiration date for the physician prescription is the earlier of either the physician’s designated expiration date on the prescription or three years, in accordance with the IDEA three-year re-evaluation requirement.

SHARS physician services are billable only when they are provided on an individual basis. The determination as to whether or not the provider needs to see the student while reviewing the student’s records is left up to the professional judgment of the provider. Therefore, billable time includes the following:

- The diagnosis or evaluation time spent with the student present
- The time spent without the student present reviewing the student’s records for the purpose of writing a prescription or referral for specific SHARS services
• The diagnosis or evaluation time spent with the student present, or the time spent without the student present reviewing the student’s records for the evaluation of the sufficiency of an ongoing SHARS service to see whether any changes are needed in the current prescription or referral for that service.

Session notes are not required for procedure code 99499; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the medical activity that was performed.

### 3.3.8.1 Physician Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>99499</td>
</tr>
</tbody>
</table>

*Place of Service: 1 = Office; 2 = Home; 9 = Other Locations

Providers must use a 15-minute unit of service for billing.

**Refer to:** Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### 3.3.9 Speech Therapy (ST)

#### 3.3.9.1 Referral

The name and complete address or the provider identifier or license number of the referring licensed physician or licensed SLP is required before ST services can be billed under SHARS. A licensed SLP’s evaluation and recommendation for the frequency, location, and duration of ST serves as the speech referral.

#### 3.3.9.2 Description of Services

ST evaluation services include the identification of children with speech or language disorders and the diagnosis and appraisal of specific speech and language disorders. ST services include the provision of speech and language services for the habilitation or prevention of communicative disorders.

ST evaluation is billable on an individual (procedure code 92506) basis only. ST is billable on an individual (procedure code 92507) or group (procedure code 92508) basis.

Providers can only bill time spent with the student present, including assisting the student with learning to use adaptive equipment and assistive technology.

Time spent without the student present, such as report writing and training teachers or aides to work with the student (unless the student is present during training), is not billable. Session notes are not required for procedure code 92506; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., speech evaluation).

Session notes are required for procedure codes 92507 and 92508. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

#### 3.3.9.3 Provider and Supervision Requirements

ST services are eligible for reimbursement when they are provided by a qualified SLP, who holds a Texas license or an ASHA-equivalent SLP (has a master’s degree in the field of speech-language pathology and a Texas license). ST services are also eligible for reimbursement when provided by an SLP with a state education agency certification, a licensed SLP intern, or a grandfathered SLP when acting under the supervision or direction of an SLP.
The supervision must meet the following provisions:

- The supervising SLP must provide supervision that is sufficient to ensure the appropriate completion of the responsibilities that were assigned.
- The direct involvement of the supervising SLP in overseeing the services that were provided must be documented.
- The SLP who provides the direction must ensure that the personnel who carry out the directives meet the minimum qualifications set forth in the rules of the State Board of Examiners for Speech-Language Pathology and Audiology which relate to Licensed Interns or Assistants in Speech-Language Pathology.

CMS interprets “under the direction of a speech-language pathologist,” as an SLP who:

- Is directly involved with the individual under his direction.
- Accepts professional responsibility for the actions of the personnel he agrees to direct.
- Sees each student at least once.
- Has input about the type of care provided.
- Reviews the student’s speech records after the therapy begins.
- Assumes professional responsibility for the services provided.

### 3.3.9.4 Speech Therapy Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Therapist or Licensed/Certified Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>92506 with modifier GN</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92507 with modifier GN and U8</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92507 with modifier GN and U1</td>
<td>Individual</td>
<td>Licensed/certified assistant acting under the supervision or direction of an SLP</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92508 with modifier GN and U8</td>
<td>Group</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92508 with modifier GN and U1</td>
<td>Group</td>
<td>Licensed/certified assistant acting under the supervision or direction of an SLP</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

**Refer to:** Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (individual or group) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### 3.3.10 Transportation Services in a School Setting

Transportation services in a school setting may be reimbursed when they are provided on a specially adapted vehicle and if the following criteria are met:

- Provided to or from a Medicaid-covered service on the day for which the claim is made
- A child requires transportation in a specially adapted vehicle to serve the needs of the disabled
• A child resides in an area that does not have school bus transportation, such as those in close proximity to a school
• The Medicaid services covered by SHARS are included in the student’s IEP
• The special transportation service is included in the student’s IEP

A specially adapted vehicle is one that has been physically modified (e.g., addition of a wheelchair lift, addition of seatbelts or harnesses, addition of child protective seating, or addition of air conditioning). A bus monitor or other personnel accompanying children on the bus is not considered an allowable special adaptive enhancement for Medicaid reimbursement under SHARS specialized transportation. Specialized transportation services reimbursable under SHARS requires the Medicaid-eligible special education student has the following documented in his or her IEP:

• The student requires a specific physical adaptation or adaptations of a vehicle in order to be transported
• The reason the student needs the specialized transportation

Children with special education needs who ride the regular school bus to school with other nondisabled children are not required to have the transportation services in a school setting listed in their IEP. Also, the cost of the regular school bus ride cannot be billed to SHARS. Therefore, the fact that a child may receive a service through SHARS does not necessarily mean that the transportation services in a school setting may be reimbursed for them.

Reimbursement for covered transportation services is on a student one-way trip basis. If the student receives a billable SHARS service (including personal care services on the bus) and is transported on the school’s specially adapted vehicle, the following one-way trips may be billed:

• From the student’s residence to school
• From the school to the student’s residence
• From the student’s residence to a provider’s office that is contracted with the district
• From a provider’s office that is contracted with the district to the student’s residence
• From the school to a provider’s office that is contracted with the district
• From a provider’s office that is contracted with the district to the student’s school
• From the school to another campus to receive a billable SHARS service
• From the campus where the student received a billable SHARS service back to the student’s school

Covered transportation services from a child’s residence to school and return are not reimbursable if, on the day the child is transported, the child does not receive Medicaid services covered by SHARS (other than transportation). Documentation of each one-way trip provided must be maintained by the school district (e.g., trip log). This service must not be billed by default simply because the student is transported on a specially adapted bus.

### 3.3.10.1 Transportation Services in a School Setting Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>T2003</td>
<td>Per one-way trip</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

The recommended maximum billable units for procedure code T2003 is a total of four one-way trips per day.
3.3.11 Prior Authorization
Prior authorization is not required for SHARS services.

3.4 Documentation Requirements

3.4.1 Record Retention
Student-specific records that are required for SHARS become part of the student’s educational records and must be maintained for seven years. All records that are pertinent to SHARS billings must be maintained by the school district until all audit questions, appeal hearings, investigations, or court cases are resolved. Records must be stored in a readily accessible location and format and must be available for state or federal audits.

The following is a checklist of the minimum documents to collect and maintain:

- IEP
- Current provider qualifications (licenses)
- Attendance records
- Prescriptions and referrals
- Medical necessity documentation (e.g., diagnoses and history of chronic conditions or disability)
- Session notes or service logs, including provider signatures
- Supervision logs
- Special transportation logs
- Claims submittal and payment histories

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

3.5 Claims Filing and Reimbursement
During the cost report period, school districts participating in SHARS are reimbursed on an interim claiming basis using district-specific interim rates. It is important that SHARS providers understand that SHARS interim payments are provisional in nature. The total allowable costs for providing services for SHARS must be documented by submitting the required annual cost report.

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

Claims must be submitted within 365 days from the date of service, or no later than 95 days after the end of the Federal Fiscal Year (i.e., January 3), whichever comes first.

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

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

3.5.1.1 Appealing Denied SHARS Claims

SHARS providers that appeal claims denied for exceeding benefit limitations must submit documentation of medical necessity with the appeal. Documentation submitted with an appeal must include the pages from the IEP and ARD documents that show the authorization of the services, including the specified frequency and duration and the details of the need for additional time or the reasons for exceeding the benefit limitations.

Each page of the documentation must have the client’s name and Medicaid number.

3.5.1.2 Billing Units Based on 15 Minutes

All claims for reimbursement are based on the actual amount of billable time associated with the SHARS service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units must be rounded up or down to the nearest quarter hour.

Reminder: Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information may be reimbursed as a unit of 1.

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Examples:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 min–7 mins</td>
<td>0 units</td>
</tr>
<tr>
<td>8 mins–22 mins</td>
<td>1 unit</td>
</tr>
<tr>
<td>23 mins–37 mins</td>
<td>2 units</td>
</tr>
<tr>
<td>38 mins–52 mins</td>
<td>3 units</td>
</tr>
<tr>
<td>53 mins–67 mins</td>
<td>4 units</td>
</tr>
<tr>
<td>68 mins–82 mins</td>
<td>5 units</td>
</tr>
</tbody>
</table>

3.5.1.3 Billing Units Based on an Hour

All claims for reimbursement are based on the actual amount of billable time associated with the SHARS service. For those services for which the unit of service is an hour (1 unit = 60 minutes = one hour), partial units must be billed in tenths of an hour and rounded up or down to the nearest six-minute increment.

Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information may be reimbursed as a unit of 1.

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student and divide by 60 to convert to billable units of service. If the total billable minutes are not divisible by 60, the minutes are converted to partial units of service as follows:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 mins–3 mins</td>
<td>0 units</td>
</tr>
<tr>
<td>4 mins–9 mins</td>
<td>0.1 unit</td>
</tr>
<tr>
<td>10 mins–15 mins</td>
<td>0.2 unit</td>
</tr>
</tbody>
</table>
3.5.2 Managed Care Clients

SHARS services are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients, but are administered by TMHP and not the client’s MCO.

3.5.3 Reimbursement

Providers are reimbursed for medical and transportation services provided under the SHARS Program on a cost basis using federally mandated allocation methodologies in accordance with 1 TAC §355.8443.

In order to accommodate participating SHARS districts that require interim cash flow to offset the financial burden of providing for students, an interim fee-for-service claiming system still exists for SHARS. The interim claims are based on district-specific interim rates but are provisional in nature.

The provider’s final reimbursement amount is arrived at by a cost report, cost reconciliation, and cost settlement process. The provider’s total costs for both direct medical and transportation services as reported in the cost report are adjusted using the federally mandated allocation methodologies.

- If a provider’s interim payments exceed the provider’s federal portion of the total certified Medicaid allowable costs, HHSC will recoup the federal share of the overpayment.
- If the provider’s federal portion of the total certified Medicaid allowable costs exceeds the interim Medicaid payments, HHSC will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

Submittal of a SHARS cost report is mandatory for each provider that requests and receives interim payments. Failure to file a SHARS cost report will result in sanctions, which includes recoupment of all interim payments for the cost report period in which the default occurs.

School districts can access district-specific interim rates and published cost report guidance documents, on the HHSC website at www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml.

For additional information SHARS providers can contact a SHARS Rate Analyst via email at ra_shars@hhsc.state.tx.us or by telephone at (512) 491-1361.

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 mins–21 mins</td>
<td>0.3 unit</td>
</tr>
<tr>
<td>22 mins–27 mins</td>
<td>0.4 unit</td>
</tr>
<tr>
<td>28 mins–33 mins</td>
<td>0.5 unit</td>
</tr>
<tr>
<td>34 mins–39 mins</td>
<td>0.6 unit</td>
</tr>
<tr>
<td>40 mins–45 mins</td>
<td>0.7 unit</td>
</tr>
<tr>
<td>46 mins–51 mins</td>
<td>0.8 unit</td>
</tr>
<tr>
<td>52 mins–57 mins</td>
<td>0.9 unit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>58 mins–63 mins</td>
<td>1 unit</td>
</tr>
<tr>
<td>64 mins–69 mins</td>
<td>1.1 units</td>
</tr>
<tr>
<td>70 mins–75 mins</td>
<td>1.2 units</td>
</tr>
<tr>
<td>76 mins–81 mins</td>
<td>1.3 units</td>
</tr>
<tr>
<td>82 mins–87 mins</td>
<td>1.4 units</td>
</tr>
<tr>
<td>88 mins–93 mins</td>
<td>1.5 units</td>
</tr>
</tbody>
</table>
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.

Subsection 2.8, “Federal Medical Assistance Percentage (FMAP)” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

3.5.3.1 Quarterly Certification of Funds

SHARS providers are required to certify on a quarterly basis the amount reimbursed during the previous federal fiscal quarter. TMHP Provider Enrollment mails the quarterly Certification of Funds statement to SHARS providers after the end of each quarter of the federal fiscal year (October 1 through September 30). The purpose of the statement is to verify that the school district incurred costs on the dates of service that were funded from state or local funds in an amount equal to, or greater than, the combined total of its interim rates times the paid units of service. While the payments were received the previous federal fiscal quarter, the actual dates of service could have been many months prior. Therefore, the certification of public expenditures is for the date of service and not the date of payment.

In order to balance amounts in the Certification of Funds, providers will receive, or have access to, the Certification of Funds Claims Information Report. For help balancing the amounts in the statement, providers can contact the TMHP Contact Center at 1-800-925-9126.

Refer to: “Preliminary Information” in (Vol 1, General Information) for more information about provider relations representatives.

The Certification of Funds statement must be:

- Signed by the business officer or other financial representative who is responsible for signing other documents that are subject to audit.
- Notarized.
- Returned to TMHP within 25 calendar days of the date printed on the letter.

Failure to do so may result in recoupment of funds or the placement of a vendor hold on the provider’s payments until the signed Certification of Funds statement is received by TMHP. Providers must contact the TMHP Contact Center at 1-800-925-9126 if they do not receive their Certification of Funds statement.

On an annual basis, SHARS providers are required to certify through their cost reports their total, actual, incurred costs, including the federal share and the nonfederal share. Refer to the section below for additional information about cost reporting.

3.6 Cost Reporting, Cost Reconciliation, and Cost Settlement

CMS requires annual cost reporting, cost reconciliation, and cost settlement processes for all Medicaid SHARS services delivered by school districts. CMS requires that school districts, as public entities, not be paid in excess of their Medicaid-allowable costs and that any overpayments be recouped through the cost reconciliation and cost settlement processes. In an effort to minimize any potential recoupments, HHSC has assigned district-specific interim rates that are as close as possible to each district’s Medicaid-allowable costs for providing each SHARS service.

3.6.1 Cost Reporting

Each SHARS provider is required to complete an annual cost report for all SHARS that were delivered during the previous federal fiscal year (October 1 through September 30). The cost report is due on or before April 1 of the year following the reporting period.

School districts can access published cost report guidance documents, on the HHSC website at www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml.
The following certification forms must be submitted and received by HHSC for the cost report. The annual cost report includes two certification forms which must be completed to certify the provider’s incurred actual costs:

- Cost report certification
- Claimed expenditures

The certification forms received by HHSC for the cost report must be:

- The original certification pages.
- Signed by the business officer or other financial representative who is responsible for legally binding the district.
- Notarized.

The primary purpose of the cost report is to document the provider’s costs for delivering SHARS, including direct costs and indirect costs, and to reconcile the provider’s interim payments for SHARS with its actual total Medicaid-allowable costs. All annual SHARS cost reports that are filed are subject to desk review by HHSC or its designee.

For additional information, SHARS providers can contact a SHARS Rate Analyst via email at re_shars@hhsc.state.tx.us or by telephone at (512) 491-1361.

### 3.6.2 Cost Reconciliation and Cost Settlement

The cost reconciliation process must be completed within 24 months of the end of the reporting period covered by the annual SHARS cost report. The total Medicaid-allowable costs are compared to the provider’s interim payments for SHARS delivered during the reporting period, which results in a cost reconciliation.

If a provider has not complied with all cost report requirements or a provider’s interim payments exceed the actual certified Medicaid-allowable costs of the provider for SHARS to Medicaid clients, HHSC will recoup the federal share of the overpayment by one of the following methods:

- Offset all future claims payments to the provider until the amount of the federal share of the overpayment is recovered
- Recoup an agreed-upon percentage from future claims payments to the provider to ensure recovery of the overpayments within one year
- Recoup an agreed-upon dollar amount from future claims payments to ensure recovery of the overpayment within one year

If the actual certified Medicaid-allowable costs of a provider for SHARS exceed the provider’s interim payments, HHSC will pay the federal share of the difference to the provider in accordance with the final, actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

HHSC issues a notice of settlement that denotes the amount due to or from the provider.

### 3.6.3 Informal Review of Cost Reports Settlement

An ISD or the Superintendent, Chief Financial Officer, Business Officer, or other ISD Official with legal authority who disagrees with the adjustments made during the cost reconciliation process has the right to request an informal review of the adjustments. Requests for informal reviews must be sent by certified mail and received by HHSC within the time frame designated on the settlement notice. Furthermore, the request for informal review must include a concise statement of the specific actions or determinations the district disputes, the ISD’s recommended resolution, and any supporting documentation deemed relevant to the dispute. Failure to follow these instructions will result in the denial of the request for an informal review.
School districts can access published cost report guidance documents, on the HHSC website at www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml. For additional information, SHARS providers can contact a SHARS Rate Analyst via email at re_shars@hhsc.state.tx.us or by telephone at (512) 491-1361.

4. TEXAS HEALTH STEPS (THSTEPS) DENTAL

Medicaid dental services rules are described under Title 25 Texas Administrative Code (TAC) Part 1, Chapter 33. The online version of TAC is available at the Secretary of State’s website at www.sos.state.tx.us/tac/index.shtml. All dental providers must comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including standards for documentation and record maintenance as stated in 22 TAC §108.7, Minimum Standard of Care, General, and §108.8, Records of the Dentist.

Note: THSteps dental benefits are administered as Children’s Medicaid Dental Services by dental managed care organizations for most Medicaid fee-for-service and managed care clients who are 20 years of age and younger.

Refer to: The Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks), or to the Medicaid Managed Care Initiatives website at www.hhsc.state.tx.us/medicaid/MMC.shtml, for additional information about Children’s Medicaid Dental Services.

4.1 Enrollment

To become a provider of THSteps or intermediate care facility for persons with intellectual disability (ICF/ID) dental services, a dentist must:

- Practice within the scope of the provider’s professional licensure.
- Complete the Dental Provider Enrollment Application and return it to TMHP.

Dental providers are required to maintain an active license status with the TSBDE. TMHP receives a monthly automated board feed from TSBDE to update licensure information. If licensure cannot be verified with the automated board feed, it is the providers’ responsibility to provide a copy of the active TSBDE license to TMHP. If TSBDE has a delay in processing license applications and renewals, the provider must request a letter from TSBDE for their individual provider information and send the letter of verification of current licensure to TMHP. The letter must contain the provider’s specific identification information, license number, and licensure period.

If TMHP cannot verify a valid license at the time of enrollment, it is the providers’ responsibility to provide a copy of the active TSBDE license to TMHP.

A dental provider cannot be enrolled if his or her dental license is due to expire within 30 days; a current license must be submitted. Dental licensure for owners of a dental practice is a requirement of the Occupations Code, Vernon’s Texas Codes Annotated (VTCA), Subtitle D, Chapters 251-267 (the Texas Dental Practice Act).

Providers can download and print dental provider enrollment application forms from the TMHP website at www.tmhp.com or call the TMHP Contact Center at 1-800-925-9126 to request them.

All owners of a dental practice must maintain an active license status with the TSBDE to receive reimbursement from Texas Medicaid. Any change in ownership or licensure status for any enrolled dentist must be immediately reported in writing to TMHP Provider Enrollment and will affect reimbursement by Texas Medicaid.

A dentist must complete the Dental Provider Enrollment Application for each separate practice location and will receive a unique provider identifier for each practice location if the application is approved.
The application form includes a written agreement with HHSC.

Dental providers may enroll in the THSteps Dental program and ICF/ID Dental Programs or as a Doctor of Dentistry Practicing as a Limited Physician, or both. The enrollment requirements are different with respect to the category of enrollment.

- All dental providers must declare one or more of the following categories:
  - General practice
  - Pediatric dentist
  - Periodontist
  - Endodontist
  - Oral and maxillofacial surgeon
  - Orthodontist
  - Other (prosthodontist, public health, and others)

Dentists (D.D.S., D.M.D.) who want to provide orthodontic services must be enrolled as a dentist or orthodontist provider for THSteps and must have at least one of the qualifications listed below.

THSteps dental providers may perform and be reimbursed for orthodontic services if they have attested to at least one of the following requirements:

- Completion of a dental pediatric specialty residency
- Completion of a minimum of 200 hours of continuing education in orthodontics within the last 10 years (8 hours can be online or self instruction) (Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services; however, documentation must be produced by the dentist during retrospective review.)

Orthodontist providers are eligible to provide orthodontic services. In order to comply with the TSBDE rules and regulations, this designation can only be associated with dentists who are board-eligible or board-certified by an American Dental Association (ADA) recognized orthodontic specialty board.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information).

4.1.1 THSteps Dental Eligibility

The client must be Medicaid- and THSteps-eligible (birth through 20 years of age) at the time of the service request and service delivery. However, Medicaid-approved orthodontic services already in progress may be continued even after the client loses Medicaid eligibility if the orthodontic treatment:

- Began before the loss of Medicaid eligibility.
- Began before the day of the client’s 21st birthday.
- Was completed within 36 months of the beginning date.

The client is not eligible for a THSteps medical checkup or THSteps dental benefits if the client’s Your Texas Benefits card or Medicaid Eligibility Verification Form (Forms H1027 and H1027-A-C) states any of the following:

- Emergency care only
- Presumptive eligibility (PE)
- Qualified Medicare beneficiary (QMB)
- Texas Women’s Health Program
4.1.2 THSteps Dental and ICF/ID Dental Services
A provider may enroll as an individual dentist, a group practice, or both. Regardless of the category of practice designation under THSteps Dental, providers can only submit claims for THSteps and ICF/ID Dental Services.


4.1.3 THSteps Dental Checkup and Treatment Facilities
All THSteps dental checkup and treatment policies apply to examinations and treatment completed in a dentist’s office, a health department, clinic setting, hospital operating room, or in a mobile/satellite unit. Enrollment of a mobile/satellite unit must be under a dentist or clinic name. Mobile units can be a van or any temporary site away from the primary office and are considered extensions of that office and are not separate entities. The physical setting must be appropriate so that all elements of the checkup or treatment can be completed. The checkup must meet the requirements detailed in subsection D.5, “Parental Accompaniment” in Appendix D, “Texas Health Steps Statutory State Requirements,” of this handbook. The provider with a mobile unit or who uses portable dental equipment must obtain a permit for the mobile unit from the TSBDE.

4.1.4 Doctor of Dentistry Practicing as a Limited Physician
Dentists who serve clients and submit claims using medical (CPT) procedure codes, such as oral-maxillofacial surgeons, may enroll as a doctor of dentistry practicing as a limited physician. Providers may enroll as an individual dentist or as a dental group. To enroll as a doctor of dentistry practicing as a limited physician, a dentist must:

- Be currently licensed by the TSBDE or currently licensed in the state where the service was performed.
- Have a Medicare provider identification number before applying for a Medicaid provider identifier.
- Enroll as a Medicaid provider with a limited physician provider identifier.

4.1.5 Client Rights
Dental providers enrolled in Texas Medicaid enter into a written contract with HHSC to uphold the following rights of the Medicaid client:

- To receive dental services that meet or exceed the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- To receive information following a dental examination about the dental diagnosis; scope of proposed treatment, including alternatives and risks; anticipated results; and the need and risks for administration of sedation or anesthesia.
- To have full participation in the development of the treatment plan and the process of giving informed consent.
- To have freedom from physical, mental, emotional, sexual, or verbal abuse, or harm from the provider or staff.
- To have freedom from overly aggressive treatment in excess of that required to address documented medical necessity.

A provider’s failure to ensure any of the client rights may result in termination of the provider agreement or contract and other civil or criminal remedies.
4.1.6 Complaints and Resolution

Complaints about dental services are typically received through the TMHP Contact Center, although a complaint is accepted from any source. A complaint is researched by TMHP and resolved or escalated as appropriate. Examples of complaints from clients about providers include:

- The provider did not consult with the client, explain what services were necessary, or obtain parent or guardian informed consent.
- The treating provider refused to make the child’s record available to the new provider.
- The provider did not give the child the appropriate local anesthesia or pain medication.
- The provider did not use sterile procedures; the facility or equipment were not clean.
- The provider or his staff were verbally abusive.
- The client did not receive a service, but the provider submitted a claim to Texas Medicaid.
- The provider charged a Medicaid client for benefits covered by Medicaid.

4.2 Services, Benefits, Limitations, and Prior Authorization

4.2.1 THSteps Dental Services

THSteps is the Texas version of the Medicaid program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

THSteps dental services are mandated by Medicaid to provide for the early detection and treatment of dental health problems for Medicaid-eligible clients who are birth through 20 years of age. THSteps dental service standards are designed to meet federal regulations and incorporate the recommendations of representatives of national and state dental professional organizations.

THSteps’ designated staff (DSHS, DADS, or contractor), through outreach and informing, encourage eligible children to use THSteps dental checkups and services when children first become eligible for Medicaid, and each time children are periodically due for their next dental checkup.

Children within Medicaid have free choice of Medicaid-enrolled providers and are given names of enrolled providers. A list of THSteps dental providers in a specific area can be obtained using the Online Provider Lookup on the TMHP website at www.tmhp.com, or by calling 1-877-847-8377.

Upon a provider’s request, DSHS (or its contractor) will assist eligible children with the scheduling of free transportation to their dental appointment or clients can call the Medical Transportation Program at 1-877-633-8747.

Refer to: The Medical Transportation Program Handbook (Vol. 2, Provider Handbooks) for information about transportation arrangements.

4.2.1.1 Eligibility for THSteps Dental Services

A client is eligible for THSteps dental services from birth through 20 years of age. The eligibility period is determined by the client’s age on the first of the month. If a client’s birthday is not on the first of a month, the new eligibility period begins on the first day of the following month. When the client turns 21 years of age during a month, the client is eligible for THSteps dental non-CCP services through the end of that month.

A client is eligible for Comprehensive Care Program (CCP) dental services until their 21st birthday. The eligibility period ends on their 21st birthday and does not continue through the end of the month in which the birthday falls.
4.2.1.2 Parental Accompaniment

Children who are 14 years of age and younger must be accompanied to THSteps dental appointments by a parent, legal guardian, or another adult who is authorized by the parent or guardian unless the services are provided by an exempt entity as defined by the Human Resources Code. For additional information and exceptions, see subsection D.5, “Parental Accompaniment” in Appendix D, “Texas Health Steps Statutory State Requirements,” in this handbook.

4.2.2 Comprehensive Care Program (CCP)

The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which federal financial participation (FFP) is available, regardless of the limitations of Texas Medicaid. This expansion is referred to as the Comprehensive Care Program (CCP).

CCP services are provided only for those clients who are birth through 20 years of age who are eligible to receive THSteps services. When the client becomes 21 years of age, all CCP benefits stop. Dental services that are a benefit through CCP are designated in the Limitations column of the Medicaid dental fee schedules beginning in subsection 4.2.13, “Diagnostic Services” of this handbook, with the notation “CCP.”

4.2.3 Children’s Medicaid Dental Plan Choices

Children’s Medicaid dental services benefits are administered by two dental managed care organizations (i.e., dental plans) across the state of Texas.

<table>
<thead>
<tr>
<th>Medicaid Managed Care Dental Plan Provider Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>DentaQuest</td>
</tr>
<tr>
<td>MCNA Dental</td>
</tr>
</tbody>
</table>

Note: Services provided to Medicaid managed care clients must be provided by their main dentist.

4.2.4 Authorization Transfers for Medicaid Managed Care Dental Orthodontic Services

If a client transitions to a managed care dental plan after their orthodontic services were initially authorized by TMHP, the claims for the orthodontic services will be processed and reimbursed by the managed care dental plan. Providers should check client eligibility to identify the managed care dental plan to which the client transitions.

Claims for orthodontic services remain the responsibility of the dental managed care plan until the authorized services are completed, even if the client loses dental managed care or Medicaid eligibility.

4.2.5 ICF/ID Dental Services

ICF/ID dental services are mandated by Medicaid. Reimbursement is provided for treatment of dental problems for Medicaid-eligible residents of ICF/ID facilities who are 21 years of age and older. Residents of ICF-MR facilities who are 20 years of age and younger receive services through the regular THSteps Program. Eligibility for ICF/ID services is determined by DADS.

Procedure codes that do not have a CCP designation in the Limitations column of the dental fee schedule may be submitted in a routine manner for ICF/ID clients. These procedures must be documented as medically necessary and appropriate. ICF/ID clients are not subject to periodicity for preventive care. For procedure codes that have a CCP designation, a provider may request authorization with documentation or provide documentation on the submitted claim.

Refer to: Subsection 4.2.12, “Medicaid Dental Benefits, Limitations, and Fee Schedule” of this handbook.
4.2.5.1 THSteps and ICF/ID Provision of Dental Services

All THSteps and ICF/ID dental services must be performed by the Medicaid-enrolled dental provider except for permissible work that is delegated to a licensed dental hygienist, dental assistant, or dental technician in a dental laboratory on the premises where the dentist practices, or in a commercial laboratory registered with the TSBDE. The Texas Dental Practice Act and the rules and regulations of the TSBDE (22 TAC, Part 5) define the scope of work that dental auxiliary personnel may perform. Any deviations from these practice limitations shall be reported to the TSBDE and HHSC, and could result in sanctions or other actions imposed against the provider.

THSteps and ICF/ID clients must receive:

• Dental services specified in the treatment plan that meet the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
• Dental services free from abuse or harm from the provider or the provider’s staff.
• Only the treatment required to address documented medical necessity that meets professionally recognized standards of health care.

4.2.5.2 Children in Foster Care

Clients in foster care receive services from Superior HealthPlan’s dental contractor. Providers may contact DentaQuest at 1-888-308-9345 for more information.

Paper claims and requests for prior authorization must be mailed to:

DentaQuest
12121 North Corporate Parkway
Mequon, WI 53092
Fax: (262) 241-7150 or 1-888-313-2883

4.2.6 Written Informed Consent and Standards of Care

As outlined in 22 TAC §108.7, the dental provider must maintain written informed consent signed by the patient, or a parent or legal guardian of the patient if the patient is a minor, or a legal guardian of the patient if the patient has been adjudicated incompetent to manage the patient’s personal affairs.

Such consent is required for all treatment plans and procedures where a reasonable possibility of complications from the treatment planned or a procedure exists, and such consent should disclose risks or hazards that could influence a reasonable person in making a decision to give or withhold consent.

Written consent must be given within the one-year period prior to the date the services are provided, and must not have been revoked. THSteps clients or their parents or legal guardians who can give written informed consent must receive information following a dental examination about the dental diagnosis, scope of proposed treatment, including alternatives and risks, anticipated results, and need for and risks of the administration of sedation or anesthesia. Additionally, they must receive a full explanation of the treatment plan and give written informed consent before treatment is initiated. The parent or guardian being present at the time of the dental visit facilitates the provider obtaining written informed consent. Dentists must comply with TSBDE Rule 22 TAC §108.2, “Fair Dealing.”

4.2.7 First Dental Home

Based on the American Academy of Pediatric Dentistry’s (AAPD) definition, Texas Medicaid defines a dental home as the dental provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a client’s dental home begins no later than 6 months of age and includes referrals to dental specialists when appropriate.
In providing a dental home for a client, the dental provider enhances the ability to assist clients and their parents in obtaining optimum oral health care. The first dental home visit can be initiated as early as 6 months of age and must include, but is not limited to, the following:

- Comprehensive oral examination
- Oral hygiene instruction with primary caregiver
- Dental prophylaxis, if appropriate
- Topical fluoride varnish application when teeth are present
- Caries risk assessment
- Dental anticipatory guidance

Clients who are from 6 through 35 months of age may be seen for dental checkups by a certified First Dental Home provider.

First Dental Home services are submitted using procedure code D0145. The dental home provider must retain supporting documentation for procedure code D0145 in the client’s record. The supporting documentation must include, but is not limited to, the following:

- Oral and physical health history review
- Dental history review
- Primary caregiver’s oral health
- Oral evaluation
- Caries risk assessment
- Dental prophylaxis, which may include a toothbrush prophylaxis
- Oral hygiene instruction with parent or caregiver
- Fluoride varnish application
- An appropriate preventive oral health regimen (recall schedule)
- Anticipatory guidance communicated to the client’s parent, legal guardian, or primary caregiver to include the following:
  - Oral health and home care
  - Oral health of primary caregiver/other family members
  - Development of mouth and teeth
  - Oral habits
  - Diet, nutrition, and food choices
  - Fluoride needs
  - Injury prevention
  - Medications and oral health
  - Any referrals, including dental specialist’s name

Procedure code D0145 is limited to individual dentists certified by the DSHS Oral Health Program to perform this service. Training for certification as a First Dental Home provider is available as a free continuing education course on the THSteps website at www.txhealthsteps.com.
Procedure codes D0120, D0150, D0160, D0170, D0180, D1120, D1206, D1208, and D8660 are denied if procedure code D0145 is submitted for the same DOS by any provider. A First Dental Home examination is limited to ten services per client lifetime with at least 60 days between visits by any provider to prevent denials of the service.

4.2.8 Dental Referrals by THSteps Primary Care Providers

Dental providers may receive referrals for clients who are 6 months of age and older from THSteps primary care providers. The primary care provider must provide information about the initiation of routine dental services with the recommendation to the client’s parent or guardian that an appointment be scheduled with a dental provider in order to establish a dental home. If a THSteps dental checkup reveals a dental health condition that requires follow-up diagnosis or treatment, the provider performing the dental checkup should assist the client in planning follow-up care within their practice or in making a referral to another qualified dental provider.

Note: For clients who are 20 years of age and younger, the client’s guardian may refer the client for dental services or a client of legal age may refer themselves for dental services.

4.2.9 Change of Provider

A provider may refer a client to another dental provider for treatment for any of the following reasons:

- Treatment by a dental specialist such as a pediatric dentist, periodontist, oral surgeon, endodontist, or orthodontist is indicated and is in the best interests of the THSteps client.
- The services needed are outside the skills or scope of practice of the initial provider.

A provider may discontinue treatment if there is documented failure to keep appointments by the client, noncompliance with the treatment plan, or conflicts with the client or other family members. In any such action to discontinue treatment, providers must comply with 22 TAC §108.5, “Patient Abandonment.”

The client also may select another provider, if desired. HHSC may refer the client to another provider as a result of adverse information obtained during a utilization review or resolution of a complaint from either provider or client.

4.2.9.1 Interrupted or Incomplete Orthodontic Treatment Plans

Authorizations for orthodontic or extensive restorative treatment plans that have been prior authorized for a provider are not transferable to another provider. If a client’s treatment plan is interrupted and the services are not completed, the original or new provider must request a new prior authorization to complete the interrupted, incomplete, and prior authorized treatment plan.

To complete the treatment plan, the client must be eligible for Medicaid. It is the provider’s responsibility to verify the client’s eligibility through www.YourTexasBenefitsCard.com, TexMedConnect, or the TMHP Contact Center.

If the client does not return for the completion of services and there is a documented failure to keep appointments by the client, the dental provider who initiated the services may submit a claim for reimbursement in compliance with the 95-day filing deadline.

Refer to: Subsection 4.2.27.4, “Premature Termination of Comprehensive Orthodontic Treatment” in this handbook.

4.2.10 Periodicity for THSteps Dental Services

For clients who are 6 months through 20 years of age, dental checkups may occur at 6-month (181-day) intervals. Texas Medicaid has adopted the AAPD’s “Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children” to serve as a guide and reference for dentists when scheduling and providing services to THSteps clients.
In November 2004, the ADA, in conjunction with the FDA, established “Guidelines for Prescribing Dental Radiographs.” The guidelines include type of encounters relevant to the client’s age and dental developmental stage. Texas Medicaid has adopted the ADA guidelines to serve as a guide and reference for dentists who treat THSteps clients.

Refer to: Subsection G.1, “American Academy of Pediatric Dentistry Periodicity Guidelines (9 Pages)” and subsection G.2, “American Dental Association Guidelines for Prescribing Dental Radiographs (3 Pages)” in this handbook.

THSteps dental providers may provide any medically necessary dental services such as emergency, diagnostic, preventive, therapeutic, and orthodontic services that are within the Texas Medicaid guidelines and limitations specified for each area as long as the client’s Medicaid eligibility is current for the date that dental services are being provided.

4.2.10.1 Exceptions to Periodicity

If a periodic dental checkup has been conducted within the last six months, the client still may be able to receive another periodic dental checkup in the same six-month period by any provider. For THSteps clients, exceptions to the six-month periodicity schedule for dental checkup services may be approved for one of the following reasons:

- Medically necessary service, based on risk factors and health needs (includes clients who are birth through 6 months of age).
- Required to meet federal or state exam requirements for Head Start, daycare, foster care, preadoption, or to provide a checkup prior to the next periodically-due checkup if the client will not be available when due. This includes clients whose parents are migrant or seasonal workers.
- Clients’ choice to request a second opinion or change service providers (not applicable to referrals).
- Subsequent therapeutic services necessary to complete a case for clients who are 5 months of age and younger when initiated as emergency services, for trauma, or early childhood caries.
- Medical checkup prior to a dental procedure requiring general anesthesia.
- A First Dental Home client can be seen up to ten times within the age of 6 through 35 months.

It is the provider’s responsibility to verify that the client is eligible for the date that dental services are to be provided. Eligibility may be verified through www.YourTexasBenefitsCard.com, TexMedConnect, or the TMHP Contact Center.

When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the client’s file and on the claim submission. For claims filed electronically, check “yes” when prompted. For claims filed on paper, place comments in Block 35.

For ICF/ID clients who are 21 years of age and older, the periodicity schedule for preventive dental procedures (exams, prophylaxis, fluoride, and radiographs) does not apply.
4.2.11 Tooth Identification (TID) and Surface Identification (SID) Systems

Claims are denied if the procedure code is not compatible with TID or SID. Use the alpha characters to describe tooth surfaces or any combination of surfaces. For SID designation on anterior teeth, use facial (F) and incisal (I). For SID purposes, use buccal (B) and occlusal (O) designations for posterior teeth.

4.2.11.1 Supernumerary Tooth Identification

Each identified permanent tooth and each identified primary tooth has its own identifiable supernumery number. This developed system can be found in the Current Dental Terminology (CDT) published by the ADA.

The TID for each identified supernumerary tooth will be used for paper and electronic claims and can only be submitted for payment with the following procedure codes:

- For primary teeth only: D7111.
- For both primary and permanent teeth the following codes can be submitted: D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7285, D7286, and D7510.

<table>
<thead>
<tr>
<th>TID</th>
<th>SID</th>
<th>SID</th>
<th>SID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buccal</td>
<td>DB</td>
<td>DFI</td>
<td>DLIF</td>
</tr>
<tr>
<td>Distal</td>
<td>DF</td>
<td>DFL</td>
<td>DOLB</td>
</tr>
<tr>
<td>Facial</td>
<td>DI</td>
<td>DFM</td>
<td>MIDF</td>
</tr>
<tr>
<td>Incisal</td>
<td>DL</td>
<td>DIL</td>
<td>MIDL</td>
</tr>
<tr>
<td>Lingual</td>
<td>DO</td>
<td>DLB</td>
<td>MIDLF</td>
</tr>
<tr>
<td>Mesial</td>
<td>IL</td>
<td>DLM</td>
<td>MIFL</td>
</tr>
<tr>
<td>Occlusal</td>
<td>MB</td>
<td>DOB</td>
<td>MLBD</td>
</tr>
<tr>
<td>MI</td>
<td>DOL</td>
<td>MLDF</td>
<td></td>
</tr>
<tr>
<td>ML</td>
<td>ILF</td>
<td>MODB</td>
<td></td>
</tr>
<tr>
<td>MO</td>
<td>MBD</td>
<td>MODL</td>
<td></td>
</tr>
<tr>
<td>OB</td>
<td>MID</td>
<td>MODLB</td>
<td></td>
</tr>
<tr>
<td>OL</td>
<td>MIF</td>
<td>MOLB</td>
<td></td>
</tr>
<tr>
<td>MLB</td>
<td>MLF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MLI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOB</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OBL</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Permanent Teeth Upper Arch

<table>
<thead>
<tr>
<th>Tooth #</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Super #</td>
<td>51</td>
<td>52</td>
<td>53</td>
<td>54</td>
<td>55</td>
<td>56</td>
<td>57</td>
<td>58</td>
<td>59</td>
<td>60</td>
<td>61</td>
<td>62</td>
<td>63</td>
<td>64</td>
<td>65</td>
<td>66</td>
</tr>
</tbody>
</table>

Permanent Teeth Lower Arch

<table>
<thead>
<tr>
<th>Tooth #</th>
<th>32</th>
<th>31</th>
<th>30</th>
<th>29</th>
<th>28</th>
<th>27</th>
<th>26</th>
<th>25</th>
<th>24</th>
<th>23</th>
<th>22</th>
<th>21</th>
<th>20</th>
<th>19</th>
<th>18</th>
<th>17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Super #</td>
<td>82</td>
<td>81</td>
<td>80</td>
<td>79</td>
<td>78</td>
<td>77</td>
<td>76</td>
<td>75</td>
<td>74</td>
<td>73</td>
<td>72</td>
<td>71</td>
<td>70</td>
<td>69</td>
<td>68</td>
<td>67</td>
</tr>
</tbody>
</table>

Primary Teeth Upper Arch

<table>
<thead>
<tr>
<th>Tooth #</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
</tr>
</thead>
<tbody>
<tr>
<td>Super #</td>
<td>AS</td>
<td>BS</td>
<td>CS</td>
<td>DS</td>
<td>ES</td>
<td>FS</td>
<td>GS</td>
<td>HS</td>
<td>IS</td>
<td>JS</td>
</tr>
</tbody>
</table>

Primary Teeth Lower Arch

<table>
<thead>
<tr>
<th>Tooth #</th>
<th>T</th>
<th>S</th>
<th>R</th>
<th>Q</th>
<th>P</th>
<th>O</th>
<th>N</th>
<th>M</th>
<th>L</th>
<th>K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Super #</td>
<td>TS</td>
<td>SS</td>
<td>RS</td>
<td>QS</td>
<td>PS</td>
<td>OS</td>
<td>NS</td>
<td>MS</td>
<td>LS</td>
<td>KS</td>
</tr>
</tbody>
</table>
4.2.12 Medicaid Dental Benefits, Limitations, and Fee Schedule

For THSteps clients, dental procedure limitations may be waived when all the following have been met. The dental procedure is:

- Medically necessary and FFP is available for it.
- Prior authorized by the TMHP Dental Director.
- Properly documented in the client’s record.

Refer to: Subsection 4.3, “Documentation Requirements” in this handbook.

For ICF/ID clients, services designated as CCP-type are available. In the Limitations column of the fee schedule, abbreviations indicate the age range limitations and documentation requirements. The following abbreviations also appear in a table at the bottom of each page of the fee schedule:

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Age range limitations</td>
</tr>
<tr>
<td>CCP</td>
<td>Payable under CCP for clients who are 20 years of age and younger when THSteps benefits or limits are exceeded</td>
</tr>
<tr>
<td>DOS</td>
<td>Date of service</td>
</tr>
<tr>
<td>FMX</td>
<td>Intraoral radiographs—complete series</td>
</tr>
<tr>
<td>MTID</td>
<td>Missing tooth ID(s)</td>
</tr>
<tr>
<td>N</td>
<td>Narrative of medical necessity for the procedure must be retained in the client’s record</td>
</tr>
<tr>
<td>NC</td>
<td>Not reimbursed by Medicaid. Services may not be charged to the client.</td>
</tr>
<tr>
<td>PATH</td>
<td>Pathology report must accompany the claim and must be retained in the client’s record</td>
</tr>
<tr>
<td>PC</td>
<td>Periodontal charting must be retained in the client’s record</td>
</tr>
<tr>
<td>PHO</td>
<td>Preoperative and postoperative photographs required and must be maintained in the client’s medical record</td>
</tr>
<tr>
<td>PPXR</td>
<td>Preoperative and postoperative radiographs are required when the procedure is performed and must be retained in the client’s record; do not send with initial claims</td>
</tr>
<tr>
<td>PXR</td>
<td>Preoperative radiographs are required when the procedure is performed and must be retained in the client’s record; do not send with initial claims</td>
</tr>
</tbody>
</table>

4.2.13 Diagnostic Services

Diagnostic services should be performed for all clients, starting within the first six months of the eruption of the first primary tooth, but no later than one year of age.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Oral Evaluations</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Procedure codes D0140, D0160, D0170, and D0180 are limited dental codes and may be paid in addition to a comprehensive oral exam (procedure code D0150) or periodic oral exam (procedure code D0120), when submitted within a six-month period. When submitting a claim for procedure code D0140, D0160, D0170, or D0180, the provider must indicate documentation of medical necessity on the claim. These claims are subject to retrospective review. If no comments are indicated on the claim form, the payment may be recouped.</strong></td>
<td></td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
The provider must document medical necessity and the specific tooth or area of the mouth on the claim for procedure codes D0140, D0160, and D0170.

Documentation supporting medical necessity for procedure codes D0140, D0160, and D0170 must also be maintained by the provider in the client’s medical record and must include the following:

- The client’s complaint supporting medical necessity for the examination
- The specific area of the mouth that was examined or the tooth involved
- A description of what was done during the visit
- Supporting documentation of medical necessity which may include, but is not limited to, radiographs or photographs

Documentation supporting medical necessity for procedure code D0180 must be maintained by the provider in the client’s medical record and must include the following:

- The client’s complaint supporting medical necessity for the examination
- A description of what was done during the treatment
- Supporting documentation of medical necessity which may include, but is not limited to, radiographs or photographs

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Radiographs/Diagnostic Imaging (Including Interpretation)</strong></td>
<td></td>
</tr>
<tr>
<td>Number of films required is dependent on the age of the client. A minimum of eight films is required to be considered a full-mouth series. Adults and children who are 12 years of age and older require 12–20 films, as is appropriate. The Panorex radiographic image (D0330) with four bitewing radiographic images (D0274) may be considered equivalent to the complete or full-mouth series of radiographic images (D0210), and the submitted amount for either combination is equivalent to the maximum fee.</td>
<td></td>
</tr>
<tr>
<td>D0210</td>
<td>Limited to one service every three years by the same provider. Not allowed as an emergency service. A 2–20</td>
</tr>
<tr>
<td>D0220</td>
<td>Limited to one service per day by the same provider. A 1–20</td>
</tr>
<tr>
<td>D0230</td>
<td>The total cost of periapicals and other radiographs cannot exceed the payment for a complete intraoral series. A 1–20</td>
</tr>
<tr>
<td>D0240</td>
<td>Limited to two services per day by the same provider. Periapical films taken at an occlusal angle must be submitted as periapical radiograph, procedure code D0230. May be submitted as an emergency service. A Birth–20</td>
</tr>
<tr>
<td>D0250</td>
<td>Limited to one service per day by the same provider. A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0260</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0270</td>
<td>Limited to one service per day by the same provider. A 1–20</td>
</tr>
<tr>
<td>D0272</td>
<td>Limited to one service per day by the same provider. A 1–20</td>
</tr>
<tr>
<td>D0273</td>
<td>Limited to one service per day by the same provider. A 1–20</td>
</tr>
<tr>
<td>D0274</td>
<td>Limited to one service per day by the same provider. A 2–20</td>
</tr>
<tr>
<td>D0277</td>
<td>Limited to one service per day by the same provider. Not to be submitted within 36 months of D0210 or D0330. A 2–20</td>
</tr>
<tr>
<td>D0290</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0310</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0320</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0321</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0322</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0330*</td>
<td>Limited to one service per day, any provider, and to one service every three years by the same provider. Not allowed on emergency claims unless third molars or a traumatic condition is involved. For clients who are 2 years of age and younger, must document the necessity of a panoramic film. The Panorex radiographic image (D0330) with four bitewing radiographic images (D0274) may be considered equivalent to the complete or full-mouth series of radiographic images (D0210), and the submitted amount for either combination is equivalent to the maximum fee. A 3–20</td>
</tr>
<tr>
<td>D0340*</td>
<td>Limited to one service per day by the same provider. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A 1–20, N, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
Procedure code D0350 must be used to submit claims for photographs, and will be accepted only when diagnostic-quality radiographs cannot be taken. Supporting documentation and photographs must be maintained in the client’s medical record when medical necessity is not evident on radiographs for dental caries or the following procedure codes. Medical necessity must be documented on the electronic or paper claim.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0350*</td>
<td>Limited to one service per day by the same provider. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A Birth–20</td>
</tr>
<tr>
<td>D0363*</td>
<td>Prior authorization is required. Limited to a combined maximum of three services per year (with procedure code D0367), any provider. Additional services may be considered with documentation of medical necessity. A Birth–20</td>
</tr>
<tr>
<td>D0367</td>
<td>Prior authorization is required. Limited to a combined maximum of three services per year (with procedure code D0363), any provider. Additional services may be considered with documentation of medical necessity. A Birth–20</td>
</tr>
</tbody>
</table>

*Note: Radiograph codes do not include the exam. If an exam is also performed, providers must submit the appropriate ADA procedure code.*

Procedure code D0350 must be used to submit claims for photographs, and will be accepted only when diagnostic-quality radiographs cannot be taken. Supporting documentation and photographs must be maintained in the client’s medical record when medical necessity is not evident on radiographs for dental caries or the following procedure codes. Medical necessity must be documented on the electronic or paper claim.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0415</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0425</td>
<td>Not reimbursable separately. Considered part of another dental procedure.</td>
</tr>
<tr>
<td>D0460</td>
<td>Limited to one service per day by the same provider. Not payable for primary teeth. Will deny when submitted for the same DOS as any endodontic procedure. A 1-20, N, CCP</td>
</tr>
</tbody>
</table>

Tests and Examinations continued

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0470*</td>
<td>Not reimbursable separately when crown, fixed prosthodontics, diagnostic workup, or crossbite therapy workup is performed. A 1-20, N, CCP</td>
</tr>
</tbody>
</table>

Oral Pathology Laboratory

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0472</td>
<td>By pathology laboratories only. (refer to CPT codes)</td>
</tr>
<tr>
<td>D0473</td>
<td>By pathology laboratories only. (refer to CPT codes)</td>
</tr>
<tr>
<td>D0474</td>
<td>By pathology laboratories only. (refer to CPT codes)</td>
</tr>
<tr>
<td>D0480</td>
<td>By pathology laboratories only. (refer to CPT codes)</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
### 4.2.14 Preventive Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Prophylaxis</strong></td>
<td></td>
</tr>
<tr>
<td>D1110*</td>
<td>Limited to one prophylaxis per client, same provider, per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. A 13–20</td>
</tr>
<tr>
<td>D1120*</td>
<td>Limited to one prophylaxis per client, same provider, per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code, or with procedure code D0145. A 6 months–12 years</td>
</tr>
<tr>
<td><strong>Topical Fluoride Treatment (Office Procedure)</strong></td>
<td></td>
</tr>
<tr>
<td>D1206</td>
<td>Includes oral health instructions. Denied when submitted for the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. A 6 months–20 years, N, CCP</td>
</tr>
<tr>
<td>D1208</td>
<td>Includes oral health instructions. Denied when submitted for the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. A 6 months–20 years, N, CCP</td>
</tr>
<tr>
<td><strong>Other Preventive Services</strong></td>
<td></td>
</tr>
<tr>
<td>D1310</td>
<td>Denied as part of all preventative, therapeutic and diagnostic dental procedures. A client requiring more involved nutrition counseling may be referred to a THSteps primary care physician.</td>
</tr>
<tr>
<td>D1320</td>
<td>A client requiring tobacco counseling may be referred to a THSteps primary care provider.</td>
</tr>
<tr>
<td>D1330</td>
<td>Requires documentation of the type of instructions, number of appointments, and content of instructions. This procedure refers to services above and beyond routine brushing and flossing instruction and requires that additional time and expertise have been directed toward the client’s care. Denied when billed for the same DOS as dental prophylaxis (D1110 or D1120) or topical fluoride treatments (D1206 or D1208) by the same provider. Limited to once per client, per year, by any provider. A 1–20, N, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
### Therapeutic Services

Medicaid reimbursement is contingent on compliance with the following limitations:

- **Documentation requirements**
  - Refer to Subsection 4.3, “Documentation Requirements” in this handbook.
  - Total restorative fee per tooth on primary teeth cannot exceed $156.06, which is the fee for a stainless steel crown (exceptions: D2335 and D2933).
  - All fees for tooth restorations include local anesthesia and pulp protective media, where indicated, without additional charges. These services are considered part of the restoration.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1351*</td>
<td>Sealants may be applied to the occlusal, buccal, and lingual pits and fissures of any tooth that is at risk for dental decay and is free of proximal caries and free of restorations on the surface to be sealed. Sealants are a benefit when applied to deciduous (baby or primary) teeth or permanent teeth. Indicate the tooth numbers and surfaces on the claim form. Reimbursement will be considered on a per-tooth basis, regardless of the number of surfaces sealed. Denied when billed for the same DOS as any D4000 series periodontal procedure code. Sealants and replacement sealants are limited to one every 3 years per tooth by the same provider or provider group. Dental sealants performed more frequently than once every three years by a different provider are also a benefit if the different provider is not associated with the provider or provider group that initially placed the sealant on the tooth. A Birth–20</td>
</tr>
</tbody>
</table>

| D1352          | A 1–20 |

**Space Maintenance (Passive Appliances)**

Space maintainers are a benefit of Texas Medicaid after premature loss of primary or secondary molars (TID A, B, I, J, K, L, S, and T for clients who are 1 through 12 years of age, and after loss of permanent molars (TID 3, 14, 19, and 30) for clients who are 3 through 20 years of age. Limited to 1 space maintainer per TID per client.

When procedure code D1510 or D1515 have been previously reimbursed, the recementation of space maintainers (procedure code D1550) may be considered for reimbursement to either the same or different THSteps dental provider. Replacement space maintainers may be considered upon appeal with documentation supporting medical necessity. Removal of a fixed space maintainer is not payable to the provider or dental group practice that originally placed the device.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A 1–20 (TIDs #3, 14, 19, 30), MTID</td>
</tr>
</tbody>
</table>

**Space Maintenance (Passive Appliances) continued**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A 1–20 (TIDs #3, 14, 19, 30), MTID</td>
</tr>
<tr>
<td></td>
<td>A 1–20 (TIDs #3, 14, 19, 30), MTID</td>
</tr>
<tr>
<td></td>
<td>A 1–20 (TIDs #3, 14, 19, 30), MTID</td>
</tr>
<tr>
<td></td>
<td>A 1–20 (TIDs #3, 14, 19, 30), MTID</td>
</tr>
<tr>
<td></td>
<td>A 1–20 (TIDs #3, 14, 19, 30), MTID</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
More than one restoration on a single surface is considered a single restoration.

Multiple surface restorations must show definite crossing of the plane of each surface listed for each primary and permanent tooth completed.

A multiple surface restoration cannot be submitted as two or more separate one-surface restorations.

Restorations and therapeutic care are provided as a Medicaid service based on medical necessity and reimbursed only for therapeutic reasons and not preventive purposes (refer to CDT).

All dental restorations and prosthetic appliances that require lab fabrication may be submitted for reimbursement using the date the final impression was made as the DOS. If the client did not return for final seating of the restoration or appliance, a narrative must be included on the claim form and in the client’s chart in lieu of a postoperative radiograph. The 95-day filing deadline is in effect from the date of the final impression. If the client returns to the office after the claim has been filed, the dentist is obligated to attempt to seat the restoration or appliance at no cost to the client or Texas Medicaid. For records retention requirements, refer to subsection 4.3, “Documentation Requirements” in this handbook.

Direct pulp caps may be reimbursed separately from any final tooth restoration performed on the same tooth (as noted by the TID) on the same DOS by the same provider.

### 4.2.16 Restorative Services

#### Amalgam Restorations (Including Polishing)

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140*</td>
<td>A Birth–20, PXR</td>
</tr>
<tr>
<td>D2150*</td>
<td>A Birth–20, PXR</td>
</tr>
<tr>
<td>D2160*</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D2161*</td>
<td>A 1–20, PXR</td>
</tr>
</tbody>
</table>

#### Resin-Based Composite Restorations—Direct

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2390*</td>
<td>A Birth–20, PXR</td>
</tr>
<tr>
<td>D2391*</td>
<td>A Birth–20, PXR</td>
</tr>
<tr>
<td>D2392*</td>
<td>A Birth–20, PXR</td>
</tr>
<tr>
<td>D2393*</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D2394*</td>
<td>A 1–20, PXR</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
### Inlay/Onlay Restorations (Permanent Teeth only)

For procedure codes D2510 through D2664, inlay/onlay (permanent teeth only), porcelain is allowed on all teeth. Prior authorization is required for any combination of inlays/onlays or permanent crowns that exceed the limit of four inlays/onlays or permanent crowns per lifetime, any provider.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2510</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2520</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2530</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2542</td>
<td>Same as D2520. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2543</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2544</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2650</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2651</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2652</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2662</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2663</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2664</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
</tbody>
</table>

### Crowns—Single Restorations Only

For procedure codes D2710 through D2794, single crown restorations (permanent teeth only), the following limitations apply:

- Prior authorization is required for any combination of inlays/onlays or permanent crowns that exceed the limit of four inlays/onlays or permanent crowns per lifetime, any provider.

Stainless steel crowns and permanent all-metal cast crowns are not reimbursed on anterior permanent teeth (6–11, 22–27).

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2710</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2720</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2721</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2722</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2740</td>
<td>All materials accepted. A 17–20, N, PPXR, CCP. Limited to TID #6–11 and 22–27 only.</td>
</tr>
<tr>
<td>D2750*</td>
<td>All materials accepted. A 17–20, N, PPXR, CCP. Limited to TID #6–11 and 22–27 only.</td>
</tr>
<tr>
<td>D2751*</td>
<td>All materials accepted. A 17–20, N, PPXR. Limited to TID #6–11 and 22–27 only.</td>
</tr>
<tr>
<td>D2752</td>
<td>All materials accepted. A 17–20, N, PPXR, CCP. Limited to TID #6–11 and 22–27 only.</td>
</tr>
<tr>
<td>D2780</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2781</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2782</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
</tbody>
</table>

A = Age range limitations, N = Narrative required, FMX = Full-mouth radiographs (nonpanoramic), MTID = Missing tooth ID(s), PPXR = Preoperative and postoperative radiographs required, PXR = Preoperative radiographs required, PHO = Preoperative and postoperative photographs required, PC = Periodontal charting required, PATH = Pathology report required and must be retained in the client’s record, CCP = Comprehensive Care Program, NC = No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2783</td>
<td>Anterior teeth only (#6–11 and 22–27). A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2790</td>
<td>Posterior teeth only (#1–5, 12–21, and 28–32). All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2791*</td>
<td>Posterior teeth only (#1–5, 12–21, and 28–32). All materials accepted. A 13–20, N, PPXR</td>
</tr>
<tr>
<td>D2792*</td>
<td>Posterior teeth only (#1–5, 12–21, and 28–32). All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2794</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
</tbody>
</table>

### Other Restorative Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2910</td>
<td>A 13–20, PXR</td>
</tr>
<tr>
<td>D2915</td>
<td>A 4–20</td>
</tr>
<tr>
<td>D2920</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D2930*</td>
<td>A Birth–20, PXR</td>
</tr>
<tr>
<td>D2931*</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D2932*</td>
<td>A 1–20, PXR (primary tooth)</td>
</tr>
<tr>
<td>D2933*</td>
<td>Limited to anterior primary teeth only (TID #C–H, M–R). A Birth–20, N, CCP, PXR</td>
</tr>
<tr>
<td>D2934*</td>
<td>Limited to anterior primary teeth only (TID #C–H, M–R). A Birth–20, N, CCP, PXR</td>
</tr>
<tr>
<td>D2940*</td>
<td>Not allowed on the same date as permanent restoration. A Birth–20, PXR</td>
</tr>
<tr>
<td>D2950*</td>
<td>Provider payments received in excess of $45.00 for restorative work performed within six months of a crown procedure on the same tooth will be deducted from the subsequent crown procedure reimbursement. Not allowed on primary teeth. A 4–20, N, CCP, PXR</td>
</tr>
<tr>
<td>D2951</td>
<td>Not allowed on primary teeth. A 4–20, PXR</td>
</tr>
<tr>
<td>D2952</td>
<td>Not payable with D2950. Not allowed on primary teeth. A 13–20, CCP, PXR</td>
</tr>
<tr>
<td>D2953</td>
<td>Must be used with D2952. Not allowed on primary teeth. A 13–20</td>
</tr>
<tr>
<td>D2954*</td>
<td>Not payable with D2952 or D3950 on the same TID by the same provider. Not allowed on primary teeth. A 13–20, N, CCP, PXR</td>
</tr>
<tr>
<td>D2955</td>
<td>For removal of posts (for example, fractured posts) not to be used in conjunction with endodontic retreatment (D3346, D3347, D3348). Not allowed on primary teeth. A 4–20, CCP, PXR</td>
</tr>
<tr>
<td>D2957</td>
<td>Must be used with D2954. Not allowed on primary teeth. A 13–20, PXR, CCP</td>
</tr>
<tr>
<td>D2960</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2961</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2962</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
4.2.17 Endodontics Services

Therapeutic pulpotomy (procedure code D3220) and apexification and recalcification procedures (procedure codes D3351, D3352, and D3353) are considered part of the root canal (procedure codes D3310, D3320, and D3330) or retreatment of a previous root canal (procedure codes D3346, D3347, and D3348). When therapeutic pulpotomy or apexification and recalcification procedures are submitted with root canal codes, the reimbursement rate is adjusted to ensure that the total amount reimbursed does not exceed the total dollar amount allowed for the root canal procedure.

Reimbursement for a root canal includes all appointments necessary to complete the treatment. Pulpotomy and radiographs performed pre, intra, and postoperatively are included in the root canal reimbursement.

Root canal therapy that has only been initiated, or taken to some degree of completion, but not carried to completion with a final filling, may not be submitted as a root canal therapy code. It must be submitted using code D3999 with a narrative description of what procedures were completed in the root canal therapy.

Documentation supporting medical necessity must be kept in the client’s record and include the following: the medical necessity as documented through periapical radiographs of tooth treated showing pre-treatment, during treatment, and post-treatment status; the final size of the file to which the canal was enlarged; and the type of filling material used. Any reason that the root canal may appear radiographically unacceptable must be documented in the client’s record.

If the client is pregnant and does not want radiographs, use alternative treatment (temporary) until after delivery.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2970</td>
<td>May be reimbursed once per lifetime for each tooth, any provider.</td>
</tr>
<tr>
<td>D2971*</td>
<td>May be reimbursed up to four services per lifetime for each tooth. Payable to any THSteps dental provider who performed the original cementation of the crown. A 13–20</td>
</tr>
<tr>
<td>D2980</td>
<td>A 1–20, PXR (permanent teeth only)</td>
</tr>
<tr>
<td>D2999</td>
<td>A 1–20, N, CCP, PXR</td>
</tr>
</tbody>
</table>

D2970 May be reimbursed once per lifetime for each tooth, any provider.

D2971* May be reimbursed up to four services per lifetime for each tooth. Payable to any THSteps dental provider who performed the original cementation of the crown. A 13–20

D2980 A 1–20, PXR (permanent teeth only)

D2999 A 1–20, N, CCP, PXR

**Procedure Code** | **Limitations**
---|---
**Pulp Capping**

Procedure codes D3110 and D3120 will not be reimbursed when submitted with the following procedure codes for the same tooth, for the same DOS, by the same provider: D2952, D2953, D2954, D2955, D2957, D2980, D2999, D3220, D3230, D3240, D3310, D3320, or D3330.

D3110 A 1–20, N, PXR, CCP

D3120 A 1–20, N, PXR, CCP

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pulpotomy</strong></td>
<td></td>
</tr>
<tr>
<td>D3220*</td>
<td>Denied when performed within six months of D3230, D3240, D3310, D3320, or D3330 for the same primary TID, same provider. Denied when performed within six months of D3310, D3320, or D3330 on the same permanent TID, same provider. A Birth–20, PXR</td>
</tr>
<tr>
<td><strong>Endodontic Therapy on Primary Teeth</strong></td>
<td></td>
</tr>
<tr>
<td>D3230*</td>
<td>Anterior primary incisors and cuspids. TIDs #C–H, M–R. A 1–20, PXR</td>
</tr>
<tr>
<td><strong>Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)</strong></td>
<td></td>
</tr>
<tr>
<td>D3310*</td>
<td>A 6–20, PPXR</td>
</tr>
<tr>
<td>D3320*</td>
<td>A 6–20, PPXR</td>
</tr>
<tr>
<td>D3330*</td>
<td>A 6–20, PPXR</td>
</tr>
<tr>
<td><strong>Endodontic Retreatment</strong></td>
<td></td>
</tr>
<tr>
<td>D3346*</td>
<td>A 6–20, PPXR</td>
</tr>
<tr>
<td>D3347*</td>
<td>A 6–20, PPXR</td>
</tr>
<tr>
<td>D3348*</td>
<td>A 6–20, PPXR</td>
</tr>
<tr>
<td><strong>Apexification/Recalcification Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>D3351*</td>
<td>A 6–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D3352*</td>
<td>A 6–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D3353*</td>
<td>A 6–20, PPXR, CCP</td>
</tr>
<tr>
<td>D3354*</td>
<td></td>
</tr>
<tr>
<td><strong>Apicoectomy/Periradicular Services</strong></td>
<td></td>
</tr>
<tr>
<td>D3410</td>
<td>A 6–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D3421</td>
<td>A 6–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D3425</td>
<td>A 6–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D3426</td>
<td>A 6–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D3430</td>
<td>A 6–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D3450</td>
<td>A 6–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D3460</td>
<td>Prior authorization required. Submit request with periapical radiographs, for each tooth involved. A 16–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D3470</td>
<td>A 6–20, N, PXR, CCP</td>
</tr>
<tr>
<td><strong>Other Endodontic Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>D3910</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D3920</td>
<td>A 6–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D3950</td>
<td>A 6–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D3999</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
4.2.18 Periodontal Services

Procedure codes D4210 and D4211, when submitted for clients who are 12 years of age and younger, will be initially denied, but may be appealed with documentation of medical necessity. Preoperative and postoperative photographs are required for the following procedure codes: D4210, D4211, D4270, D4273, D4275, D4276, D4277, D4278, D4355, and D4910.

Preoperative and postoperative photographs are required when medical necessity is not evident on radiographs for the following procedure codes: D4240, D4241, D4245, D4266, and D4267. Documentation is required when medical necessity is not evident on radiographs for the following procedure codes: D4210, D4211, D4240, D4241, D4245, D4266, D4267, D4270, D4273, D4275, D4276, D4277, D4278, D4355, and D4910.

Procedure code D4278 must be billed on the same date of service as procedure code D4277 or the service will be denied.

Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, and D1351 will be denied when submitted for the same DOS as any D4000 series periodontal procedure codes.

Procedure codes D4266 and D4267 may be appealed with documentation of medical necessity. Medical necessity for third molar sites are:

- Medical or dental history documenting need due to inadequate healing of bone following third molar extraction, including the date of third molar extraction.
- Secondary procedure several months postextraction.
- Position of the third molar preoperatively.
- Postextraction probing depth to document continuing bony defect.
- Postextraction radiographs documenting continuing bony defect.
- Bone graft and barrier material used.

Medical necessity for other than third molar sites are:

- Medical or dental history documenting comorbid condition (e.g., juvenile diabetes, cleft palate, avulsed tooth or teeth, traumatic oral injuries).
- Intra- or extra-oral radiographs of treatment site(s).
- If not radiographically evident, intraoral photographs are optional unless requested preoperatively by HHSC or its agent.
- Periodontal probing depths.
- Number of intact walls associated with an angular bony defect.
- Bone graft and barrier material used.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Services (Including Usual Postoperative Care)</td>
<td></td>
</tr>
<tr>
<td>D4210</td>
<td>A 13–20, N, PPXR, PHO, CCP</td>
</tr>
<tr>
<td>D4211</td>
<td>A 13–20, N, PHO, CCP</td>
</tr>
<tr>
<td>D4230</td>
<td>A 13–20, N, PHO, PXR, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4231</td>
<td>A 13–20, N, PHO, PXR, CCP</td>
</tr>
<tr>
<td>D4240</td>
<td>A 13–20, N, FMX, PXR, PHO when medical necessity is not evident on radiographs, PC, CCP</td>
</tr>
<tr>
<td>D4241</td>
<td>Limited to once per year. A 13–20, N, FMX, PXR, PHO when medical necessity is not evident on radiographs, PC</td>
</tr>
<tr>
<td>D4245</td>
<td>Per quadrant. A 13–20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP</td>
</tr>
<tr>
<td>D4249</td>
<td>A six- to eight-week healing period following crown lengthening before final tooth preparation, impression making, and fabrication of a final restoration is required for claims submission of this code. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D4260</td>
<td>A 13–20, N, FMX, PXR, PC, CCP</td>
</tr>
<tr>
<td>D4266</td>
<td>Limited to once per year. A 13–20, N, FMX, PXR, PC</td>
</tr>
<tr>
<td>D4267</td>
<td>A 13–20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP</td>
</tr>
<tr>
<td>D4270</td>
<td>A 13–20, N, PXR, PHO, CCP</td>
</tr>
<tr>
<td>D4273</td>
<td>This procedure is performed to create or augment gingiva, to obtain root coverage or to eliminate frenum pull, or to extend the vestibular fornix. A 13–20, N, PXR, PHO, CCP</td>
</tr>
<tr>
<td>D4274</td>
<td>This procedure is performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are used to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation. A 13–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D4275</td>
<td>Limited to once per day. A 13–20, PXR, PHO</td>
</tr>
<tr>
<td>D4276</td>
<td>Prior authorization is required. Not payable in addition to D4273 or D4275 for the same DOS. A 13–20, PXR, PHO</td>
</tr>
<tr>
<td>D4277</td>
<td>A 13–20, N, PXR, PHO, CCP</td>
</tr>
<tr>
<td>D4278</td>
<td>A 13–20, N, PXR, PHO, CCP</td>
</tr>
</tbody>
</table>

**Nonsurgical Periodontal Services**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4320</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D4321</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D4341*</td>
<td>D4341 is denied if provided within 21 days of D4355. Denied when submitted for the same DOS as other D4000 series codes or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525. A 13–20, FMX, PC, PXR, CCP</td>
</tr>
<tr>
<td>D4342</td>
<td>Denied when submitted for the same DOS as other D4000 series codes or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525. A 13–20, PC, FMX</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *=Services payable to an FQHC for a client encounter
4.2.19 Prosthodontic (Removable) Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4355*</td>
<td>D4355 is not payable if provided within 21 days of D4341. Denied when submitted for the same DOS as other D4000 series codes or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525. A 13–20, N, PXR, PHO, CCP</td>
</tr>
<tr>
<td>D4381</td>
<td>This procedure does not replace conventional or surgical therapy required for debridement, respective procedures, or regenerative therapy. The use of controlled-release chemotherapeutic agents is an adjunctive therapy or for cases in which systemic disease or other factors preclude conventional or surgical therapy. A 13–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

Other Periodontal Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4910</td>
<td>Payable only following active periodontal therapy by any provider as evidenced either by a submitted claim for procedure code D4240, D4241, D4260, or D4261 or by evidence through client records of periodontal therapy while not Medicaid-eligible. Not payable within 90 days after D4355, not payable for the same DOS as any other evaluation procedure. Limited to once per 12 calendar months by the same provider. A 13–20, N, PXR, PHO, CCP</td>
</tr>
<tr>
<td>D4920</td>
<td>A 13–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D4999</td>
<td>A 13–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

Complete Dentures (Including Routine Post Delivery Care)

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>A 3–20, PXR</td>
</tr>
<tr>
<td>D5120</td>
<td>A 3–20, PXR</td>
</tr>
<tr>
<td>D5130</td>
<td>A 13–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5140</td>
<td>A 13–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

Partial Dentures (Including Routine Post Delivery Care)

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5211*</td>
<td>A 6–20, PXR, MTID</td>
</tr>
<tr>
<td>D5212*</td>
<td>A 6–20, PXR, MTID</td>
</tr>
<tr>
<td>D5213</td>
<td>A 9–20, N, PXR, MTID, CCP</td>
</tr>
<tr>
<td>D5214</td>
<td>A 9–20, N, PXR, MTID, CCP</td>
</tr>
<tr>
<td>D5281*</td>
<td>A 9–20, N, PXR, MTID, CCP</td>
</tr>
</tbody>
</table>

Adjustments to Dentures

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5410</td>
<td>A 3–20, PXR</td>
</tr>
<tr>
<td>D5411</td>
<td>A 3–20, PXR</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *=Services payable to an FQHC for a client encounter
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5421</td>
<td>A 6–20, PXR</td>
</tr>
<tr>
<td>D5422</td>
<td>A 6–20, PXR</td>
</tr>
</tbody>
</table>

**Repairs to Complete Dentures**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5510</td>
<td>Cost of repairs cannot exceed replacement costs. A 3–20, PXR</td>
</tr>
<tr>
<td>D5520</td>
<td>Cost of repairs cannot exceed replacement costs. A 3–20, PXR</td>
</tr>
</tbody>
</table>

**Repairs to Partial Dentures**

Cost of repairs cannot exceed replacement costs. The laboratory portion of the claim, not to exceed $137.50, must be submitted.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5610*</td>
<td>A 3–20, PXR</td>
</tr>
<tr>
<td>D5620</td>
<td>A 6–20, PXR</td>
</tr>
<tr>
<td>D5630*</td>
<td>A 6–20, PXR</td>
</tr>
<tr>
<td>D5640*</td>
<td>A 6–20, PXR</td>
</tr>
<tr>
<td>D5650*</td>
<td>A 6–20, PXR</td>
</tr>
<tr>
<td>D5660*</td>
<td>A 6–20, PXR</td>
</tr>
<tr>
<td>D5670*</td>
<td>Will be denied as part of procedure codes D5211, D5213, D5281, and D5640. A 6–20</td>
</tr>
<tr>
<td>D5671*</td>
<td>Will be denied as part of procedure codes D5212, D5214, D5281, and D5640. A 6–20</td>
</tr>
</tbody>
</table>

**Denture Rebase Procedures**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5710</td>
<td>A 4–20, PXR</td>
</tr>
<tr>
<td>D5711</td>
<td>A 4–20, PXR</td>
</tr>
<tr>
<td>D5720*</td>
<td>A 7–20, PXR</td>
</tr>
<tr>
<td>D5721*</td>
<td>A 7–20, PXR</td>
</tr>
</tbody>
</table>

**Denture Reline Procedures**

Allowed whether or not the denture was obtained through THSteps or ICF/ID dental services if the reline makes the denture serviceable.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5730</td>
<td>A 4–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5731</td>
<td>A 4–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5740*</td>
<td>A 7–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5741*</td>
<td>A 7–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5750</td>
<td>A 4–20, PXR</td>
</tr>
<tr>
<td>D5751</td>
<td>A 4–20, PXR</td>
</tr>
<tr>
<td>D5760*</td>
<td>A 7–20, PXR</td>
</tr>
<tr>
<td>D5761*</td>
<td>A 7–20, PXR</td>
</tr>
</tbody>
</table>

**Interim Prosthesis**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5810</td>
<td>A 3–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5811</td>
<td>A 3–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5820</td>
<td>A 3–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5821</td>
<td>A 3–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

### Other Removable Prosthetic Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5850</td>
<td>A 3–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5851</td>
<td>A 3–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5860</td>
<td>A 4–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5861</td>
<td>A 4–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5862</td>
<td>A 4–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5899</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

### Maxillofacial Prosthetics

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5911</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5912</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5913</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5914</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5915</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5916</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5919</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5922</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5923</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5924</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5925</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5926</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5927</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5928</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5929</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5931</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5932</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5933</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5934</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5935</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5936</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5937</td>
<td>Not for temporo-mandibular dysfunction (TMD) treatment. A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5951</td>
<td>Prior authorization. A Birth–20, N, PXR</td>
</tr>
<tr>
<td>D5952</td>
<td>Prior authorization. A Birth–20, N, PXR</td>
</tr>
<tr>
<td>D5953</td>
<td>Prior authorization. A 13–20, N, PXR</td>
</tr>
<tr>
<td>D5954</td>
<td>Prior authorization. A Birth–20, N, PXR</td>
</tr>
<tr>
<td>D5955</td>
<td>Prior authorization. A Birth–20, N, PXR</td>
</tr>
</tbody>
</table>

A = Age range limitations, N = Narrative required, FMX = Full-mouth radiographs (nonpanoramic), MTID = Missing tooth ID(s), PPXR = Preoperative and postoperative radiographs required, PXR = Preoperative radiographs required, PHO = Preoperative and postoperative photographs required, PC = Periodontal charting required, PATH = Pathology report required and must be retained in the client’s record, CCP = Comprehensive Care Program, NC = No charge to Medicaid and may not bill the client, and * = Services payable to an FQHC for a client encounter
4.2.20 Implant Services

Implant services require prior authorization.

Refer to: Subsection 4.2.32, “Mandatory Prior Authorization” in this handbook for documentation requirements.

Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by the TMHP Dental Director are:

- At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).
- Space cannot be filled with removable partial denture.
- The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).

4.2.21 Prosthodontic (Fixed) Services

Prosthodontic procedure codes require prior authorization.

Refer to: Subsection 4.2.32, “Mandatory Prior Authorization” in this handbook for documentation requirements.

Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by the TMHP Dental Director are:

- At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).
- The space cannot be filled with a removable partial denture.
- The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).
- Each abutment or each pontic constitutes a unit in a bridge.
Porcelain is allowed on all teeth.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed Partial Dental Pontics</strong></td>
<td></td>
</tr>
<tr>
<td>D6210</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6211</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6212</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6240</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6241</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6242</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6245</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6250</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6251</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6252</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td><strong>Fixed Partial Dental Retainers—Inlays/Onlays</strong></td>
<td></td>
</tr>
<tr>
<td>D6545</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6548</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td><strong>Fixed Partial Dental Retainers—Crowns</strong></td>
<td></td>
</tr>
<tr>
<td>D6720</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6721</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6722</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6740</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6750</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6751</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6752</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6780</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6781</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6782</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6783</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6790</td>
<td>Permanent posterior teeth only. A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6791</td>
<td>Permanent posterior teeth only. A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6792</td>
<td>Permanent posterior teeth only. A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td><strong>Other Fixed Partial Dental</strong></td>
<td></td>
</tr>
<tr>
<td>D6920</td>
<td>A 16–20, PXR, CCP</td>
</tr>
<tr>
<td>D6930</td>
<td>A 16–20, PXR, CCP</td>
</tr>
<tr>
<td>D6940</td>
<td>A 16–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D6950</td>
<td>A 16–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D6975</td>
<td>A 16–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

*Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.*
4.2.22 Oral and Maxillofacial Surgery Services

All oral surgery procedures include local anesthesia, suturing, if needed, and visits for routine postoperative care.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6980</td>
<td>A 16–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D6999</td>
<td>A 16–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6980</td>
<td>A 16–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D6999</td>
<td>A 16–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alveoloplasty—Surgical Preparation of Ridge for Dentures</strong></td>
<td></td>
</tr>
<tr>
<td>D7310</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7320</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td><strong>Vestibuloplasty</strong></td>
<td></td>
</tr>
<tr>
<td>D7340</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7350</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td><strong>Surgical Excision of Soft Tissue Lesions</strong></td>
<td></td>
</tr>
<tr>
<td>D7410</td>
<td>A 1–20, PXR, PATH</td>
</tr>
<tr>
<td>D7411</td>
<td>A 1–20, PXR, PATH</td>
</tr>
<tr>
<td>D7413</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
</tr>
<tr>
<td>D7414</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
</tr>
<tr>
<td><strong>Surgical Excision of Intralossesous Lesions</strong></td>
<td></td>
</tr>
<tr>
<td>D7440</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
</tr>
<tr>
<td>D7441</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
</tr>
<tr>
<td>D7450</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
</tr>
<tr>
<td>D7451</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
</tr>
<tr>
<td>D7460</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth–20, N, PXR, PATH, CCP</td>
</tr>
<tr>
<td>D7461</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth–20, N, PXR, PATH, CCP</td>
</tr>
<tr>
<td>D7465</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
</tr>
<tr>
<td><strong>Excision of Bone Tissue</strong></td>
<td></td>
</tr>
<tr>
<td>D7472</td>
<td>Prior authorization is required. A 1–20</td>
</tr>
<tr>
<td><strong>Surgical Incision</strong></td>
<td></td>
</tr>
<tr>
<td>D7510*</td>
<td>TID required. A 1–20, PXR</td>
</tr>
<tr>
<td>D7520</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative radiographs required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7530</td>
<td>A 1–20, N, PXR</td>
</tr>
<tr>
<td>D7540</td>
<td>A 1–20, N, PXR</td>
</tr>
<tr>
<td>D7550*</td>
<td>A 1–20, N, PXR</td>
</tr>
<tr>
<td>D7560</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7670</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

**Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7820</td>
<td>A 1–20, N, PXR</td>
</tr>
<tr>
<td>D7880</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7899</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

**Repair of Traumatic Wounds**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7910*</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

**Complicated Sutting**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7911</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7912</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

**Other Repair Procedures**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7955</td>
<td>A 1–20</td>
</tr>
<tr>
<td>D7960</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7970*</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7971*</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7972</td>
<td>TIDs #1, 16, 17, and 32 only; may not be paid in addition to D7971 for the same DOS. A 13–20</td>
</tr>
<tr>
<td>D7980</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7983</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7997*</td>
<td>Per arch, appliance removal (not by the dentist who placed the appliance). Includes removal of arch bar. Prior authorization is required. A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7999*</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, *= Services payable to an FQHC for a client encounter.
### 4.2.23 Adjunctive General Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unclassified Treatment</strong></td>
<td></td>
</tr>
<tr>
<td>D9110*</td>
<td>Emergency service only. The type of treatment rendered and TID must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked. Refer to subsection 4.2.30, “Emergency or Trauma Related Services for All T3Steps Clients and Clients Who Are 5 Months of Age and Younger” in this handbook.</td>
</tr>
<tr>
<td>D9120</td>
<td></td>
</tr>
<tr>
<td><strong>Anesthesia</strong></td>
<td></td>
</tr>
<tr>
<td>D9210</td>
<td>Claim form narrative must describe the situation if used as a diagnostic tool. Denied if submitted with D9248. A 1–20, N, CCP</td>
</tr>
<tr>
<td>D9211*</td>
<td>Denied if submitted with D9248. A 1–20, N, CCP</td>
</tr>
<tr>
<td>D9212*</td>
<td>Denied if submitted with D9248. A 1–20, N, CCP</td>
</tr>
<tr>
<td>D9220</td>
<td>May be submitted with D9221. May be submitted twice within a 12-month period. Denied if submitted with D9248. Dental anesthesiologists are reimbursed at an enhanced rate if the provider has a level 4 permit, TSBDE portability permit, and proof of an anesthesiology residency recognized by the American Dental Board of Anesthesiology on file with TMHP. Providers who do not have the TSBDE portability permit and proof of anesthesiology residency on file with TMHP will still be eligible for reimbursement. A 1–20</td>
</tr>
<tr>
<td>D9221</td>
<td>Must be submitted with D9220. Denied if submitted with D9248. A 1–20</td>
</tr>
<tr>
<td>D9230*</td>
<td>May not be submitted more than one per client, per day. Denied if submitted with D9248. A 1–20.</td>
</tr>
<tr>
<td>D9241</td>
<td>May be considered for reimbursement for conscious sedation services. Denied if submitted with D9248. A 1–20</td>
</tr>
<tr>
<td>D9242</td>
<td>Must be submitted with D9241. May be considered for reimbursement for additional conscious sedation services. Denied if submitted with D9248. A 1–20</td>
</tr>
<tr>
<td>D9248*</td>
<td>May be submitted twice within a 12-month period. Must comply with all TSBDE rules and AAPD guidelines, including maintaining a current permit to provide non-intravenous (IV) conscious sedation. A 1–20</td>
</tr>
<tr>
<td><strong>Professional Consultation</strong></td>
<td></td>
</tr>
<tr>
<td>D9310</td>
<td>An oral evaluation by a specialist of any type who is also providing restorative or surgical services must be submitted as D0160. A 1–20, N, CCP</td>
</tr>
<tr>
<td><strong>Professional Visits</strong></td>
<td></td>
</tr>
<tr>
<td>D9410</td>
<td>Narrative required on claim form. A 1–20, N</td>
</tr>
<tr>
<td>D9420</td>
<td>One charge per hospital or Ambulatory Surgery Center (ASC) case; one case per client in a 12-month period. Documentation supporting the reason that dental services could not be performed in the office setting must be retained in the client’s record and may be subject to retrospective review and recoupment. A 1–20, N</td>
</tr>
</tbody>
</table>

*A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PPHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter*
**Procedure Code** | **Limitations**
---|---
D9430 | During regularly scheduled hours, no other services performed. Visits for routine postoperative care are included in all therapeutic and oral surgery fees. A 1–20, N
D9440 | Visits for routine postoperative care are included in all therapeutic and oral surgery fees. A 1–20, N

**Drugs**

Procedure code D9630 is not payable for take home fluorides or drugs. Prescriptions should be given to clients to be filled by the pharmacy for these medications as the pharmacy is reimbursed by the Medicaid Vendor Drug Program. Procedure code D9630 is payable for medications (antibiotics, analgesics, etc.) administered to a client in the provider’s office. Documentation of dosage and route of administration must be provided in the Remarks section of the claim.

*Refer to:* Appendix B: Vendor Drug Program (*Vol. 1, General Information*).

D9610 | May not be submitted with code D9220 or D9221. A 1–20, N
D9612 | 
D9630 | Includes, but is not limited to, oral antibiotics, oral analgesic, and oral sedatives administered in the office. May not be submitted with codes D9220, D9221, D9230, D9241, D9248, D9610, and D9920. A 1–20, N

**Miscellaneous Services**

D9910 | Per whole mouth application, does not include fluoride. Not to be used for bases, liners, or adhesives under or with restorations. Limited to once per year. A 18–20, N, CCP
D9920 | The provider must indicate the client’s medical diagnosis of intellectual disability using one of the following diagnosis codes or indicate that the client is ICF/ID eligible in the Remarks field of the claim form:

- 317 – mild intellectual disability (IQ 50–70)
- 3180 – moderate intellectual disability (IQ 35–49)
- 3181 – severe intellectual disability (IQ 20–34)
- 3182 – profound intellectual disability (IQ under 20)
- 319 – unspecified intellectual disability

Documentation supporting the medical necessity and appropriateness of dental behavior management must be retained in the client’s chart and available to state agencies upon request, and is subject to retrospective review. Documentation of medical necessity must include:

- A current physician statement addressing the intellectual disability. The statement must be signed and dated within one year prior to the dental behavior management.
- A description of the service performed (including the specific problem and the behavior management technique applied).
- Personnel and supplies required to provide the behavioral management.
- The duration of the behavior management (including session start and end times).

Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure. Denied if submitted with D9248. A 1–20

---

*A=* Age range limitations, *N=* Narrative required, *FMX=* Full-mouth radiographs (nonpanoramic), *MTID=* Missing tooth ID(s), *PPXR=* Preoperative and postoperative radiographs required, *PXR=* Preoperative radiographs required, *PHO=* Preoperative and postoperative photographs required, *PC=* Periodontal charting required, *PATH=* Pathology report required and must be retained in the client’s record, *CCP=* Comprehensive Care Program, *NC=* No charge to Medicaid and may not bill the client, and *=* Services payable to an FQHC for a client encounter.
Dental providers must have the following information on file with TMHP to be eligible for reimbursement for dental anesthesia:

- A current anesthesia permit level issued by the TSBDE.
- A portability permit from the TSBDE (required to be reimbursed for anesthesia provided in a location other than the provider’s office or satellite office). If the provider does not have a permit, the services will be denied.
- Providers must have a level 4 permit, a TSBDE portability permit, and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to bill the enhanced rate for procedure code D9220.

All dental providers must comply with the American Academy of Pediatric Dentistry (AAPD) guidelines and TSBDE rules and regulations, including the standards for documentation and record maintenance for dental anesthesia.

**Anesthesia Permit Levels**
The following table shows the levels of anesthesia permits that are issued by the TSBDE:

<table>
<thead>
<tr>
<th>Permit Level</th>
<th>Description of Level</th>
<th>Permit Privileges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nitrous oxide/oxygen inhalation conscious sedation</td>
<td>Stand-alone permit</td>
<td></td>
</tr>
<tr>
<td>Level 1</td>
<td>Minimal sedation</td>
<td>Stand-alone permit</td>
</tr>
<tr>
<td>Level 2</td>
<td>Moderate enteral</td>
<td>Automatically qualifies for Level 1 and Level 2 permit privileges</td>
</tr>
<tr>
<td>Level 3</td>
<td>Moderate parenteral</td>
<td>Automatically qualifies for Level 1, Level 2, and Level 3 permit privileges</td>
</tr>
<tr>
<td>Level 4</td>
<td>Deep sedation/general anesthesia</td>
<td>Automatically qualifies for Level 1, Level 2, Level 3, and Level 4 permit privileges</td>
</tr>
</tbody>
</table>

**Anesthesia Permit Levels**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9930*</td>
<td>Prior authorization is required. A 1–20, N</td>
</tr>
<tr>
<td>D9940</td>
<td>A 13–20, N, CCP</td>
</tr>
<tr>
<td>D9950</td>
<td>A 13–20, N, CCP</td>
</tr>
<tr>
<td>D9951</td>
<td>Full mouth procedure. Limited to once per year, per client, any provider. A 13–20, N, CCP</td>
</tr>
<tr>
<td>D9952</td>
<td>Full mouth procedure. Payable once per lifetime, any provider. A 13–20, N, CCP</td>
</tr>
<tr>
<td>D9970</td>
<td>One service per day, any provider. A 13–20</td>
</tr>
<tr>
<td>D9974*</td>
<td>Claim must include documentation of medical necessity. A 13–20, CCP</td>
</tr>
<tr>
<td>D9999*</td>
<td>A 1–20, N, CCP, PPXR</td>
</tr>
</tbody>
</table>
Providers will be reimbursed only for those procedure codes that are covered by their anesthesia permit level. The following table indicates the anesthesia procedure codes and the minimum anesthesia permit level to be reimbursed for the procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Minimum Anesthesia Permit Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9211</td>
<td>Level 3</td>
</tr>
<tr>
<td>D9212</td>
<td>Level 3</td>
</tr>
<tr>
<td>D9220</td>
<td>Level 4</td>
</tr>
<tr>
<td>D9221</td>
<td>Level 4</td>
</tr>
<tr>
<td>D9230</td>
<td>Stand-alone permit for nitrous oxide/oxygen inhalation conscious sedation or Level 1</td>
</tr>
<tr>
<td>D9241</td>
<td>Level 3</td>
</tr>
<tr>
<td>D9242</td>
<td>Level 3</td>
</tr>
<tr>
<td>D9248</td>
<td>Level 2</td>
</tr>
</tbody>
</table>

Local anesthesia in conjunction with operative or surgical services (procedure code D9215) is all inclusive with any other dental service and is not reimbursed separately.

### 4.2.25 Dental Therapy Under General Anesthesia

Providers must comply with TSBDE Rules and Regulations, Chapter 8, Subsection C and 22 TAC §108.30 – 108.35. Any anesthesia type services are paid only to the provider. The dental provider is responsible for determining whether a client meets the minimum criteria necessary for receiving general anesthesia. A local anesthesia fee is *not* paid in addition to other restorative, operative, or surgical procedure fees.

Prior authorization is required for the use of general anesthesia while rendering treatment (to include the anesthesia fee and the facility fee), regardless of place of service, for a client who does not meet the requirements of the “Criteria for Dental Therapy Under General Anesthesia” (22 point threshold) and the “Criteria for Dental Therapy Under General Anesthesia, Attachment 1” forms. Supporting documentation, including the appropriate narrative, must be submitted to TMHP for prior authorization. Prior authorization is required for medically necessary dental general anesthesia that exceeds once per six months, per client, per provider. The dental provider is responsible for obtaining prior authorization for the services performed under general anesthesia. Hospitals, ASCs, and anesthesiologists must obtain the prior authorization number from the dental provider.

**Refer to:** Form CH.14, “THSteps Dental Criteria for Dental Therapy Under General Anesthesia (2 Pages)” in this handbook. Dental rehabilitation or restoration services requiring general anesthesia are performed in an outpatient facility.

Surgical services related to THSteps dental services requiring general anesthesia must be coded as follows:

- Procedure code 00170 with modifier EP is for the anesthesiologist or certified registered nurse anesthetist (CRNA) to use on the claim form.
- Procedure code 41899 with modifier EP is for the facility to use on the claim form. Procedure code 41899 does not require prior authorization for ASCs and Hospital-based Ambulatory Surgical Centers (HASCs).
- An appropriate diagnosis code, such as 52100 or 5220, must be used on the claim form.
- Modifier EP identifies that the service is associated with THSteps.
The claim forms used are the CMS-1500 or the UB-04 CMS-1450 paper claim forms. The examining physician, anesthesiologist, hospital, ASC, or HASC must submit claims to TMHP separately for the medical and facility components of their services.

**Refer to:** Form CH.13, “THSteps Dental Mandatory Prior Authorization Request Form” in this handbook.
4.2.25.1 Criteria for Dental Therapy Under General Anesthesia

Criteria for Dental Therapy Under General Anesthesia

Total points needed to justify treatment under general anesthesia=22.

<table>
<thead>
<tr>
<th>Age of client at time of examination</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than four years of age</td>
<td>8</td>
</tr>
<tr>
<td>Four and five years of age</td>
<td>6</td>
</tr>
<tr>
<td>Six and seven years of age</td>
<td>4</td>
</tr>
<tr>
<td>Eight years of age and older</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Requirements (Carious and/or Abscessed Teeth)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 teeth or one sextant</td>
<td>3</td>
</tr>
<tr>
<td>3-4 teeth or 2-3 sextants</td>
<td>6</td>
</tr>
<tr>
<td>5-8 teeth or 4 sextants</td>
<td>9</td>
</tr>
<tr>
<td>9 or more teeth or 5-6 sextants</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavior of Client **</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely negative--unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability</td>
<td>10</td>
</tr>
<tr>
<td>Somewhat negative--defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator’s hand, refusal to take radiographs</td>
<td>4</td>
</tr>
<tr>
<td>Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal responses and are not indications for treatment under general anesthesia</td>
<td>0</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

<table>
<thead>
<tr>
<th>Additional Factors **</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention**</td>
<td>15</td>
</tr>
<tr>
<td>Failed conscious sedation**</td>
<td>15</td>
</tr>
<tr>
<td>Medically compromising of handicapping condition**</td>
<td>15</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

I understand and agree with the dentist’s assessment of my child’s behavior.

PARENT/GUARDIAN SIGNATURE: ___________________________ DATE: ________________

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the client’s chart. The client’s chart must be available for review by representatives of TMHP and/or HHSC.

PERFORMING DENTIST’S SIGNATURE: ___________________________

DATE: ________________ License No. __________________________

Effective Date: 01/01/2009/Revised Date: 12/17/2008
4.2.25.2 Criteria for Dental Therapy Under General Anesthesia, Attachment 1

Medicaid Dental Policy Regarding Criteria for Dental Therapy Under General Anesthesia–Attachment 1

Purpose: To justify I.V. Sedation or General Anesthesia for Dental Therapy, the following documentation is required in the Child’s Dental Record.

Elements: Note those required* and those as appropriate**: 

1) The medical evaluation justifying the need for anesthesia
2) Description of relevant behavior and reference scale
3) Other relevant narrative justifying the need for general anesthesia.
4) Client’s demographics, including date of birth.
5) Relevant dental and medical history.
6) Dental radiographs, intraoral\perioral photography and/or diagram of dental pathology.
7) Proposed Dental Plan of Care.
8) Consent signed by parent\guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained.
10) The parent/guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist’s assessment of their child’s behavior.
11) Dentist’s attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand alone form.

“I attest that the client’s condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the client’s record and is available in my office.”

REQUESTING DENTIST’S SIGNATURE: ____________________________DATE: ________________

Effective Date_01012009/Revised Date_12172008
4.2.26 Hospitalization and ASC/HASC

Dental services performed in an ASC, HASC, or a hospital (either as an inpatient or an outpatient) may be benefits of THSteps based on the medical or behavioral justification provided, or if one of the following conditions exist:

- The procedures cannot be performed in the dental office.
- The client is severely disabled.

To satisfy the preadmission history and physical examination requirements of the hospital, ASC, or HASC, a THSteps medical checkup for dental rehabilitation or restoration may be performed by the child’s primary care provider. Physicians who are not enrolled as THSteps medical providers must submit claims for the examination of a client before the procedure with the appropriate evaluation and management procedure code from the following table:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Place of Service (POS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>POS 1 (office)</td>
</tr>
<tr>
<td>99222</td>
<td>POS 3 (inpatient hospital)</td>
</tr>
<tr>
<td>99282</td>
<td>POS 5 (outpatient hospital)</td>
</tr>
</tbody>
</table>

Refer to: Subsection 4.2.10.1, “Exceptions to Periodicity” in this handbook.

Note: The dental provider must submit claims to TMHP using the ADA Dental Claim Form to be considered for reimbursement through THSteps Dental Services.

The dental provider is responsible for obtaining prior authorization for the services performed under general anesthesia. Hospitals, ASC’s, and anesthesiologists must obtain the prior authorization number from the dental provider.

Contact the individual HMO for precertification requirements related to the hospital procedure. If services are precertified, the provider receives a precertification number effective for 90 days.

In those areas of the state with Medicaid managed care, the provider should contact the managed care plan for specific requirements or limitations. It is the dental provider’s responsibility to obtain precertification from the client’s HMO or managed care plan for facility and general anesthesia services if precertification is required.

To be reimbursed by the HMO, the provider must use the HMO’s contracted facility and anesthesia provider. These services are included in the capitation rates paid to HMOs, and the facility or anesthesiologist risk nonpayment from the HMO without such approval. Coordination of all specialty care is the responsibility of the client’s primary care provider. The primary care provider must be notified by the dentist or the HMO of the planned services.

Dentists providing sedation or anesthesia services must have the appropriate current permit from the TSBDE for the level of sedation or anesthesia provided.

The dental provider must be in compliance with the guidelines detailed in General Information.

Note: Post-treatment authorization will not be approved for codes that require mandatory prior authorization.

4.2.27 Orthodontic Services (THSteps)

Orthodontic services are a benefit for THSteps clients who are 13 years of age and older who have either permanent dentition and a severe handicapping malocclusion or one of the following special medical conditions:

- Cleft palate
- Head-trauma injury involving the oral cavity
• Skeletal anomalies involving the oral cavity

A severe handicapping malocclusion is defined by Texas Medicaid as dysfunctional masticatory (chewing) capacity as a result of the existing relationship between the maxillary (upper) and mandibular (lower) dental arches or teeth that without correction will result in damage to the temporomandibular joint(s) (TMJ) or other supporting oral structures (e.g., bone, tissues, intra- or extra-oral muscles, etc.).

Exception to the age restriction may be considered for clients who are 12 years of age and younger if medical necessity has been verified by the dental director for one of the following:

• Interceptive orthodontic treatment services
• Crossbite therapy
• Limited orthodontic treatment and minor treatment to control harmful habits
• Special medical conditions

Dental services that are not covered by THSteps Dental Services but are medically necessary and allowable may be a benefit under CCP according to federal Medicaid guidelines and TAC.

As required by the Texas Human Resources Code, if the client is 14 years of age and younger and services are not provided by an exempt entity, THSteps dental providers shall require the client to be accompanied to THSteps dental appointments by a parent, guardian, or other adult who is authorized by the parent or guardian.

Exempt entities (school health clinics, Head Start program, or childcare facilities) that provide services must as a condition of reimbursement:

• Obtain written, unrevoked consent for the services from the client’s parent or legal guardian within a one-year period before the date of service.
• Encourage parental involvement in and management of the health care of the clients who receive services from the clinic, program, or facility.

The following definitions of dentition established by the ADA’s Current Dental Terminology (CDT) manual are recognized by Texas Medicaid:

• Primary Dentition: Teeth developed and erupted first in order of time.
• Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
• Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.
• Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

The American Association of Orthodontists classification of occlusion or malocclusion is as follows:

• Class I: A Class I occlusion exists with the teeth in a normal relationship when the mesialbuccal cusp of the maxillary first permanent molar coincides with the buccal groove of the mandibular first molar.
• Class II: A Class II malocclusion occurs when the mandibular teeth are distal or behind the normal relationship with the maxillary teeth. This can be due to a deficiency of the lower jaw or an excess of the upper jaw and therefore, presents two types:
  • Division I is when the mandibular arch is behind the upper jaw with a consequential protrusion of the upper front teeth.
• Division II exists when the mandibular teeth are behind the upper teeth, with a retrusion of the maxillary front teeth. Both of these malocclusions have a tendency toward a deep bite because of the uncontrolled migration of the lower front teeth upwards.

• **Class III:** A Class III malocclusion occurs when the lower dental arch is in front of (mesial to) the upper dental arch. People with this type of occlusion usually have a strong or protrusive chin, which can be due to either horizontal mandibular excess or horizontal maxillary deficiency. Commonly referred to as an underbite.

### 4.2.27.1 Benefits and Limitations for Orthodontic Services

Comprehensive orthodontic services must be provided by a board-eligible or board-certified orthodontist.

*Note:* Exceptions to a board-eligible or board-certified orthodontist may be considered for clients in a rural or frontier area or where access to care is an issue.

The diagnostic workup is considered part of the pre-orthodontic treatment visit (procedure code D8660). The following procedure codes are used to submit claims for the diagnostic workup:

<table>
<thead>
<tr>
<th>Diagnostic Workup Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0330</td>
</tr>
</tbody>
</table>

Comprehensive orthodontic services include all of the following:

- Diagnostic workups
- Banding
- Initial brackets
- Replacement brackets
- Monthly visits
- Initial retainers
- Special orthodontic treatment appliance(s)

The following procedure codes are used to submit claims for orthodontic services:

<table>
<thead>
<tr>
<th>Orthodontic Services Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8080</td>
</tr>
</tbody>
</table>

Full banding is allowed on permanent dentition only, and treatment should be accomplished in one stage and is limited to once per lifetime.

Exception: Cases of mixed dentition may be considered when the treatment plan includes extractions of remaining primary teeth or in the case of cleft palate.

### 4.2.27.2 Crossbite Therapy

Crossbites (anterior and posterior) are defined by the American Academy of Pediatric Dentistry (AAPD) as malocclusions involving one or more teeth in which the maxillary teeth occlude lingually with the mandibular antagonistic (opposing) teeth. A crossbite can be of a dental or skeletal origin or a combination of both.

The intent of crossbite therapy is to prevent the need for comprehensive orthodontic treatment. This treatment may lessen the severity or future effects of a malformation, eliminate its cause, or may include localized tooth movement.
Crossbite therapy (limited orthodontics) is allowed for primary or transitional dentition. Crossbite therapy will not be considered for transitional dentition when there is a need for full banding of the adult teeth.

Crossbite therapy must be submitted with procedure code D8050 or D8060. Clients with special medical conditions may be considered for interceptive orthodontic services of the primary dentition if the services are medically necessary and submitted with procedure code D8050.

Crossbite therapy is an inclusive charge for treating the crossbite to completion. Adjustments, maintenance, diagnostic models, and diagnostic workup procedures are not reimbursed separately.

### 4.2.27.3 Minor Treatment to Control Harmful Habits

Special orthodontic appliances are a benefit for minor treatment to control harmful habits.

Orthodontic appliances for minor treatment to control harmful habits must be submitted with procedure codes D8210, D8220, and D8670.

Monthly adjustments (procedure code D8670) for minor treatment to control harmful habits are limited up to 10 visits.

Claims for panoramic films (procedure code D0330), cephalometric films (procedure code D0340), oral/facial photographic images (procedure code D0350) and diagnostic models (procedure code D0470) will be denied when they are submitted with procedure code D8210 or D8220.

Each orthodontic appliance (procedure code D8210 and D8220) are limited to once per arch, per lifetime.

### 4.2.27.4 Premature Termination of Comprehensive Orthodontic Treatment

Premature termination of comprehensive orthodontic treatment includes the following:

- Removal of the brackets and arch wires
- Removal of appliances with the fabrication of retainers
- Delivery of orthodontic retainers

Documentation of one of the following must be retained for premature termination of comprehensive orthodontic treatment:

- Documentation of a lack of cooperation from the client.
- Documentation that the client requested premature removal and a release of liability form has been signed by the parent, guardian, or client if he or she is at least 18 years of age.

Premature termination of comprehensive orthodontic treatment must be submitted with procedure code D8680.

Removal of the appliance (procedure code D8680) will be denied if the claim is submitted by any provider on the same date of service as orthodontic treatment (procedure codes D8050, D8060, and D8080).

Providers must keep a copy of the release of liability form on file and are responsible for this documentation during a review process.

If premature removal of the appliances is requested before completion of treatment, future orthodontic services may not be considered. The provider must document why the premature removal was necessary.

### 4.2.27.5 Other Orthodontic Services

Replacement brackets (procedure code D8690) are a benefit when the client transfers from one provider to another or when trauma is involved.
Providers are responsible for any replacement brackets that are required as part of the comprehensive orthodontic treatment. Additional reimbursement for replacement brackets (procedure code D8690) is limited to a combined total amount of $100.00, same provider.

Rebonding, recementing, or repair of fixed orthodontic appliances (procedure code D8693) may be reimbursed once per lifetime per orthodontic appliance.

Only one retainer per arch per lifetime (procedure code D8680) is allowed; however, each retainer may be replaced with prior authorization once per lifetime due to loss or breakage. Retainer adjustments are not reimbursed separately.

Appliances required as part of the cleft palate treatment plan may be reimbursed separately.

Special orthodontic appliances may be used with full banding and crossbite therapy when approved by the TMHP Dental Director or Associate Dental Director.

4.2.27.6 Non-covered Services

Single arch comprehensive orthodontic treatment is not a benefit of Texas Medicaid.

Orthodontic services that are performed solely for cosmetic purposes are not a benefit of Texas Medicaid. Although aesthetics is an important part of self-esteem, services primarily for self-worth are not within the scope of this Texas Medicaid benefit.

Orthodontic services for a client who initiated orthodontic treatment through a private arrangement while Medicaid-eligible are not a benefit of Texas Medicaid.

An initial orthodontic or pre-orthodontic treatment visit (procedure code D8660) is considered part of the exam in an oral evaluation (procedure codes D0120 or D0150).

4.2.27.7 Comprehensive Orthodontic Treatment

Comprehensive orthodontic services (procedure code D8080) are restricted to clients who are 13 years of age and older or clients who have exfoliated all primary dentition.

National procedure codes do not allow for any work-in-progress or partial submission of a claim by separating the three orthodontic components: diagnostic workup, orthodontic appliance (upper), or orthodontic appliance (lower).

When submitting claims for comprehensive orthodontic treatment procedure code D8080, three local codes must be submitted as remarks codes along with procedure code D8080. Local codes (procedure codes Z2009, Diagnostic workup approved; Z2011, Orthodontic appliance, upper; or Z2012, Orthodontic appliance, lower) must be placed in the Remarks Code field on electronic claims or Block 35 on paper claims.

Note: If the remarks code and procedure code D8080 are not submitted, the claim will be denied.

Each remarks code pays the correct reimbursement rate which, when combined, totals the maximum payment of $775. Procedure code D8080 must be submitted on three separate details, with the appropriate remarks code, even if the claim submission is for the workup and full banding. Submission of only one detail for a total of $775 will not be accepted.

Example 1: A client is approved for full banding, but after the initial workup, the client discontinues treatment. This provider would submit the national procedure code D8080 and place the local code Z2009, Diagnostic workup approved, in the Remarks/comment field. The claim would pay $175.

Example 2: A client is approved for full banding. The provider continues treatment and places the maxillary bands. The provider would submit the national procedure code D8080 and place the local procedure code Z2009, Diagnostic workup approved, and Z2011, Maxillary bands, in the Remarks/comment field. The claim would pay $475.
All electronic claims for procedure code D8080 must have the appropriate remarks code associated with the procedure code.

Providers must adhere to the following guidelines for electronic claim submission so TMHP can accurately apply the correct remarks code to the appropriate claim detail.

A Diagnostic Procedure Code (DPC) remarks code must be submitted, only once, in the first three bytes of the NTE02 at the 2400 loop.

**Example 1:** For a claim with one detail, submitted with procedure code D8080 and remarks code Z2009, enter the information as follows: DPCZ2009. The total submitted would be $175.

**Example 2:** For a claim with two details, where details one and two are procedure code D8080 and the remarks codes are Z2009 and Z2011, enter the information as follows: DPCZ2009Z2011. The total submitted would be $475.

**Example 3:** For a claim with three details, where all three details are submitted separately with procedure code D8080, enter the remarks code based on the order of the claim detail as follows: DPCZ2009Z2011Z2012. The total submitted would be $775.

This method ensures accurate and appropriate payment for services rendered and addresses the need for submission of a partial claim.

### 4.2.27.8 Orthodontic Procedure Codes and Fee Schedule

When submitting claims for orthodontic procedures, use the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orthodontic Services</strong></td>
<td></td>
</tr>
<tr>
<td>D0330*, D0340*, D0350*, and D0470*</td>
<td>A 1-20</td>
</tr>
<tr>
<td>D7280</td>
<td></td>
</tr>
<tr>
<td><strong>Interceptive Orthodontic Treatment</strong></td>
<td></td>
</tr>
<tr>
<td>D8050*</td>
<td>Replaces Z2018 and 8110D. Limited to one per lifetime.</td>
</tr>
<tr>
<td>D8060*</td>
<td>Replaces Z2018 and 8120D. Limited to one per lifetime.</td>
</tr>
<tr>
<td><strong>Comprehensive Orthodontic Treatment</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Minor Treatment to Control Harmful Habits</strong></td>
<td></td>
</tr>
<tr>
<td>D8210*</td>
<td>Refer to subsection 4.2.28, “Special Orthodontic Appliances” in this handbook for associated remarks field code.</td>
</tr>
<tr>
<td>D8220*</td>
<td>Refer to subsection 4.2.28, “Special Orthodontic Appliances” in this handbook for associated remarks field code.</td>
</tr>
<tr>
<td><strong>Other Orthodontic Services</strong></td>
<td></td>
</tr>
<tr>
<td>D8660*</td>
<td>Replaces Z2008. Denied when submitted for the same DOS as D0145 by any provider. Denied when submitted for the same DOS as D0120 or D0150 by the same provider.</td>
</tr>
<tr>
<td>D8670*</td>
<td>Replaces Z2013.</td>
</tr>
<tr>
<td>D8680*</td>
<td>Replaces Z2014 and Z2015; one retainer per arch per lifetime; may be replaced once because of loss or breakage (prior authorization is required).</td>
</tr>
</tbody>
</table>

* = Services payable to an FQHC for a client encounter.
4.2.28 Special Orthodontic Appliances

All removable or fixed special orthodontic appliances must be prior authorized. The prior authorization request must include both the national code and remarks code. However, prior authorization requests may omit the DPC prefix to the eight-digit remarks code.

All removable or fixed special orthodontic appliances must be submitted with national procedure code D8210 or D8220. To ensure appropriate claims processing, the DPC remarks code (local procedure code) reflecting the specific service is also required. The appropriate remarks codes must be entered on the prior authorization request form. Failure to follow the following steps will cause the claims to deny. Failure to enter the DPC remarks code and the appropriate procedure code will not result in claim denial; however, manual intervention is required to process the claim, which may result in a delay of payment.

For paper claim submissions, providers must enter the local procedure code in Block 35 (Remarks) of the 2006 ADA claim form.

For electronic submissions, providers enter the DPC remarks code in the Comments field to ensure correct authorization, accurate records, and reimbursement.

For electronic submissions other than TexMedConnect submissions, providers must follow the instructions below to ensure TMHP accurately applies the correct local procedure code to the appropriate claim detail:

- The DPC prefix must be submitted, only once, in the first three bytes of the NTE02 at the 2400 loop.
- In bytes 4–8, providers must submit the remark code (local procedure code) based on the order of the claim detail. Do not enter any spaces or punctuation between remark codes, unless to designate the detail is not submitted with D8210 or D8220.

**Example:** For a claim with three details, where details one and three are submitted with procedure code D8210 and detail two is not, enter the following information in the NTE02 at the 2400 loop: DPC1014D 1046D. (The space shows that detail two needs no local code.) If all details require a local code, enter DPC, no spaces, and the appropriate local codes.

To submit using TexMedConnect, providers must enter the local code into the Remarks Code field, located under the details header. The Remarks Code field is the field directly after the Procedure Code field. TexMedConnect submitters are not required to manually enter the DPC prefix as it is placed in the appropriate field on the TexMedConnect electronic claim.

* = Services payable to an FQHC for a client encounter.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8690*</td>
<td>Bracket replacement.</td>
</tr>
<tr>
<td>D8691</td>
<td>Not considered medically necessary.</td>
</tr>
<tr>
<td>D8692</td>
<td>Although procedure code D8692 is not a benefit of Texas Medicaid, providers can use procedure code D8680 to submit a claim for retainer(s). Providers must include local code Z2014 or Z2015 on the claim form to indicate upper or lower, as appropriate.</td>
</tr>
<tr>
<td>D8693</td>
<td>Limited to once per lifetime per orthodontic appliance.</td>
</tr>
<tr>
<td>D8999</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8690*</td>
<td>Bracket replacement.</td>
</tr>
<tr>
<td>D8691</td>
<td>Not considered medically necessary.</td>
</tr>
<tr>
<td>D8692</td>
<td>Although procedure code D8692 is not a benefit of Texas Medicaid, providers can use procedure code D8680 to submit a claim for retainer(s). Providers must include local code Z2014 or Z2015 on the claim form to indicate upper or lower, as appropriate.</td>
</tr>
<tr>
<td>D8693</td>
<td>Limited to once per lifetime per orthodontic appliance.</td>
</tr>
<tr>
<td>D8999</td>
<td></td>
</tr>
</tbody>
</table>

* = Services payable to an FQHC for a client encounter.
The following table identifies the appropriate DPC remarks codes to use when requesting prior authorization or submitting a claim for procedure code D8210 or D8220:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Remarks Code</th>
<th>Remarks Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8220*</td>
<td>DPC1000D</td>
<td>Appliance with horizontal projections</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1001D</td>
<td>Appliance with recurved springs</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1002D</td>
<td>Arch wires for crossbite correction (for total treatment)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1003D</td>
<td>Banded maxillary expansion appliance</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1004D</td>
<td>Bite plate/bite plane</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1005D</td>
<td>Bionator</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1006D</td>
<td>Bite block</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1007D</td>
<td>Bite-plate with push springs</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1008D</td>
<td>Bonded expansion device</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1010D</td>
<td>Chateau appliance (face mask, palatal exp and hawley)</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1011D</td>
<td>Coffin spring appliance</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1012D</td>
<td>Crib</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1013D</td>
<td>Dental obturator, definitive (obturator)</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1014D</td>
<td>Dental obturator, surgical (obturator, surgical stayplate, immediate temporary obturator)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1015D</td>
<td>Distalizing appliance with springs</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1016D</td>
<td>Expansion device</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1017D</td>
<td>Face mask (protraction mask)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1018D</td>
<td>Fixed expansion appliance</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1019D</td>
<td>Fixed lingual arch</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1020D</td>
<td>Fixed mandibular holding arch</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1021D</td>
<td>Fixed rapid palatal expander</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1022D</td>
<td>Frankel appliance</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1023D</td>
<td>Functional appliance for reduction of anterior openbite and crossbite</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1024D</td>
<td>Headgear (face bow)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1025D</td>
<td>Herbst appliance (fixed or removable)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1026D</td>
<td>Inter-occlusal cast cap surgical splints</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1027D</td>
<td>Intrusion arch</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1028D</td>
<td>Jasper jumpers</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1029D</td>
<td>Lingual appliance with hooks</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1030D</td>
<td>Mandibular anterior bridge</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1031D</td>
<td>Mandibular bihelix (similar to a quad helix for mandibular expansion to attempt nonextraction treatment)</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1032D</td>
<td>Mandibular lip bumper</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1036D</td>
<td>Mandibular lingual 6x6 arch wire</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1037D</td>
<td>Mandibular removable expander with bite plane (crozat)</td>
</tr>
</tbody>
</table>

* = Services payable to an FQHC for a client encounter.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Remarks Code</th>
<th>Remarks Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8210*</td>
<td>DPC1038D</td>
<td>Mandibular ricketts rest position splint</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1039D</td>
<td>Mandibular splint</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1040D</td>
<td>Maxillary anterior bridge</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1041D</td>
<td>Maxillary bite-opening appliance with anterior springs</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1042D</td>
<td>Maxillary lingual arch with spurs</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1043D</td>
<td>Maxillary and mandibular distalizing appliance</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1044D</td>
<td>Maxillary quad helix with finger springs</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1045D</td>
<td>Maxillary and mandibular retainer with pontics</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1046D</td>
<td>Maxillary Schwarz</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1047D</td>
<td>Maxillary splint</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1048D</td>
<td>Mobile intraoral Arch-Mia (similar to a Bihelix for nonextraction treatment)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1049D</td>
<td>Modified quad helix appliance</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1050D</td>
<td>Modified quad helix appliance (with appliance)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1051D</td>
<td>Nance appliance</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1052D</td>
<td>Nasal stent</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1053D</td>
<td>Occlusal orthotic device</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1054D</td>
<td>Orthopedic appliance</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1055D</td>
<td>Other mandibular utilities</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1056D</td>
<td>Other maxillary utilities</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1057D</td>
<td>Palatal bar</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1058D</td>
<td>Post-surgical retainer</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1059D</td>
<td>Quad helix appliance held with transpalatal arch horizontal projections</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1060D</td>
<td>Quad helix maintainer</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1061D</td>
<td>Rapid palatal expander (RPE), such as quad Helix, Haas, or Menne</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1062D</td>
<td>Removable bite plate</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1063D</td>
<td>Removable mandibular retainer</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1064D</td>
<td>Removable maxillary retainer</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1065D</td>
<td>Removable prosthesis</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1066D</td>
<td>Sagittal appliance 2 way</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1067D</td>
<td>Sagittal appliance 3 way</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1068D</td>
<td>Stapled palatal expansion appliance</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1069D</td>
<td>Surgical arch wires</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1070D</td>
<td>Surgical splints (surgical stent/wafer)</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1071D</td>
<td>Surgical stabilizing appliance</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1072D</td>
<td>Thumbsucking appliance, requires submission of models</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1073D</td>
<td>Tongue thrust appliance, requires submission of models</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1074D</td>
<td>Tooth positioner (full maxillary and mandibular)</td>
</tr>
</tbody>
</table>

* = Services payable to an FQHC for a client encounter.
4.2.29 Handicapping Labio-lingual Deviation (HLD) Index

The orthodontic provider must complete and sign the HLD Index (Angle classification).

The HLD index requires the use of an HLD score sheet and a Boley gauge for measuring.

Providers should be conservative in scoring. The client must be considered severe handicapping malocclusion with dysfunctional masticatory (chewing) capacity as a result of the existing relationship between the maxillary (upper) and mandibular (lower) dental arches and/or teeth that, without correction, will result in damage to the temporomandibular joint(s) (TMJ) and/or other supporting oral structures (e.g., bone, tissues, intra and/or extra oral muscles, etc.) and have a minimum of 26 points on the HLD index to be considered for any orthodontic care other than crossbite correction. “Half-mouth” treatment cannot be approved.

With the client or models in the centric position, the HLD index is to be scored as follows. Record all measurements rounded-off to the nearest millimeter (mm). Enter a score of “0” if the condition is absent.

Cleft Palate
A cleft palate case request for mixed dentition will be considered only if narrative justification supports treatment before the client reaches full dentition.

Note: Intermittent treatment requests may exceed the allowable 26 reimbursable treatment visits.

Severe Traumatic Deviations
Refers to facial accidents only. Points cannot be awarded for congenital deformity. Severe traumatic deviations do not include traumatic occlusions for crossbites.

Overjet in Millimeters
Score the case exactly as measured. The measurement must be recorded from the most protrusive incisor, then subtract 2 mm (considered the norm), and enter the difference as the score.

Overbite in Millimeters
Score the case exactly as measured. The measurement must be recorded from the labio-incisal edge of the overlapped anterior tooth or teeth to the point of maximum coverage, then subtract 3 mm (considered the norm), and enter the difference as the score.

Mandibular Protrusion in Millimeters
Score the client exactly as measured. The measurement must be recorded from the “line of occlusion” of the permanent teeth, not from the ectopically erupted teeth in the anterior segment.

Open Bite in Millimeters
Score the case exactly as measured. Measurement must be recorded from the “line of occlusion” of the permanent teeth, not from the ectopically erupted teeth in the anterior segment. Caution is advised in undertaking treatment of open bites in older teenagers, because of the frequency of relapse.

Ectopic Eruption
An unusual pattern of eruption, such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge.
Ectopic eruption does not include teeth that are rotated or teeth that are leaning or slanted especially when the enamel-gingival junction is within the long axis of the alveolar ridge.

Note: Record the more serious condition. Do not include (score) teeth from an arch if that arch is to be counted in the category of Anterior Crowding. For each arch, either the ectopic eruption or anterior crowding may be scored, but not both.

Anterior Crowding
Arch length insufficiency must exceed 3.5 mm to be considered as crowding in either arch. Mild rotations that may react favorably to stripping or moderate expansion procedures are not to be scored as crowded.

Excessive Anterior Spacing in Millimeters
The score for this category must be the total, in millimeters, of the anterior spaces.

Providers should be conservative in scoring. Liberal scoring will not be helpful in the evaluation and approval of the case. The case must be considered dysfunctional and have a minimum of 26 points on the HLD index to qualify for any orthodontic care other than crossbite correction. Half-mouth cases cannot be approved.

The intent of the program is to provide orthodontic care to clients with handicapping malocclusion to improve function. Although aesthetics is an important part of self-esteem, services that are primarily for aesthetics are not within the scope of benefits of this program.

The proposals for treatment services should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch will be reviewed for duplication of purpose.

If attaining a qualifying score of 26 points is uncertain, providers must include a brief narrative when submitting the case. The narrative may reduce the time necessary to gain final approval and reduce shipping costs incurred to resubmit records.

Providers must properly label and protect all records (especially plaster diagnostic models) when shipping. If plaster diagnostic models are requested by and shipped to TMHP, the provider should assure that the models are adequately protected from breakage during shipping. TMHP will return intact models to the provider.
### 4.2.29.1 HLD Score Sheet

This sheet and a Boley Gauge are required to score.

**Procedure:**
- Occlude client or models in centric position.
- Record all measurements rounded-off to the nearest millimeter.
- Enter a score of 0 if the condition is absent.

**PLEASE PRINT CLEARLY:**

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Date of birth:</th>
<th>Medicaid ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: <em>(Street/City/County/State/ZIP Code)</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONDITIONS OBSERVED</th>
<th>HLD SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cleft Palate</strong></td>
<td>Score 15</td>
</tr>
<tr>
<td><strong>Severe Traumatic Deviations</strong></td>
<td>Score 15</td>
</tr>
<tr>
<td>Trauma/Accident related only</td>
<td></td>
</tr>
<tr>
<td><strong>Overjet</strong> in mm. <em>Minus 2 mm.</em></td>
<td></td>
</tr>
<tr>
<td>Example: 8 mm. – 2 mm. = 6 points</td>
<td></td>
</tr>
<tr>
<td><strong>Overbite</strong> in mm. <em>Minus 3 mm.</em></td>
<td></td>
</tr>
<tr>
<td>Example: 5 mm. – 3 mm. = 2 points</td>
<td></td>
</tr>
<tr>
<td><strong>Mandibular Protrusion</strong> in mm.</td>
<td></td>
</tr>
<tr>
<td>See definitions/instructions to score (previous page)</td>
<td>x5 =</td>
</tr>
<tr>
<td><strong>Open Bite in mm.</strong></td>
<td></td>
</tr>
<tr>
<td>See definitions/instructions to score (previous page)</td>
<td>x4 =</td>
</tr>
<tr>
<td><strong>Ectopic Eruption</strong> (Anteriors Only)</td>
<td></td>
</tr>
<tr>
<td><em>Reminder: Points cannot be awarded on the same arch for Ectopic Eruption and Crowding</em></td>
<td></td>
</tr>
<tr>
<td>Each tooth x3 =</td>
<td></td>
</tr>
<tr>
<td><strong>Anterior Crowding</strong></td>
<td>Max.</td>
</tr>
<tr>
<td><em>10 point maximum total for both arches combined</em></td>
<td>=</td>
</tr>
<tr>
<td>Labio-lingual Spread in mm.</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>=</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>For TMHP use only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Authorization Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examiner:</th>
<th>Recorder:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provider’s Signature

Please submit this score sheet with records
4.2.30 Emergency or Trauma Related Services for All THSteps Clients and Clients Who Are 5 Months of Age and Younger

THSteps clients who are birth through 5 months of age are not eligible for routine dental checkups; however:

- They can be seen for emergency dental services by the dentist at any time for trauma, early childhood caries, or other oral health problems.
- They may be referred to a dentist by their primary care provider when a medical checkup identifies the medical necessity for dental services.

Prior authorization is not required for emergency or trauma-related dental services. Claims for these dental services must be filed separately from nonemergency dental services. Only one emergency or trauma-related dental claim per client, per day, may be considered for reimbursement. Routine therapeutic procedures are not considered emergency or trauma-related procedures.

When submitting a claim for emergency or trauma-related dental services, the provider must:

- Enter the word “Emergency” or “Trauma” in the description field (Block 30) of the claim form (also enter a brief description of the CDT procedure code used). Claims are subject to retrospective review. If no comments are indicated on the claim form, the payment may be recouped.
- If checking the Other Accident box, briefly describe in the Remarks field, Block 35 of the claim form, what caused the emergency or trauma.
- Check the appropriate box in Block 45, Treatment Resulting From, of the claim form (the options to check are Occupational Illness/Injury, Auto Accident, or Other Accident).

Documentation to support the diagnosis and treatment of trauma must be retained in the client’s record.

**Note:** Indicating Trauma in the description field allows the provider to be reimbursed for treatment on an emergency, continuing, and long-term basis without regard to periodicity, subject to the client’s eligibility and program limitations. An exception to periodicity for THSteps dental services is granted automatically for immediate treatment and any future follow-up treatment, as long as each claim submitted for payment is marked “Trauma” in the Description field, Block 30, and the original date of treatment or incident is referenced in the Remarks field, Block 35.


Subsection 4.2.12, “Medicaid Dental Benefits, Limitations, and Fee Schedule” of this handbook.

4.2.31 Emergency Services for Medicaid Clients Who Are 21 Years of Age and Older

Limited dental services are available for clients who are 21 years of age and older (not residing in an ICF/ID facility) whose dental diagnosis is secondary to and causally related to a life-threatening medical condition.

4.2.31.1 Long Term Care (LTC) Emergency Dental Services
DADS provides a limited range of dental services for Medicaid-eligible residents of LTC facilities. All claims for dental services provided to LTC residents are submitted to DADS. For information, providers should contact the appropriate LTC facility or DADS at (512) 438-2633.

4.2.31.2 Laboratory Requirements
Dental laboratories must be registered with TSBDE laboratories, and technicians must not be under restrictions imposed by TSBDE or a court.

4.2.32 Mandatory Prior Authorization
Mandatory prior authorization is required for consideration of reimbursement to dental providers who render the following services:

- Orthodontia
- Implants
- Fixed prosthetic services
- Removable prosthodontics
- Dental general anesthesia
- A combination of inlays/onlays or permanent crowns in excess of four per client
- Procedure code D4276
- Procedure code D7272
- Procedure code D7472
- Limited dental services for clients who are 21 years of age and older (not residing in an ICF/ID facility) whose dental diagnosis is secondary to and causally related to a life-threatening medical condition
- Cone beam imaging

Approved orthodontic treatment plans must be initiated before the client’s loss of Medicaid eligibility and before the 21st birthday, and must be completed within 36 months of the authorization date. Authorization for other procedures is valid for up to 90 days.

To obtain prior authorization for implants and fixed prosthodontics, a prior authorization form together with documentation supporting medical necessity and appropriateness must be submitted. Required documentation includes, but is not limited to:

- The THSteps Dental Mandatory Prior Authorization Request Form.
- Appropriate pretreatment radiographs.
- Necessary radiographs of each involved tooth, such as periapical views. Panoramic films are inadequate to document caries.
- Documentation supporting that the mouth is free of disease; no untreated periodontal or endodontic disease, or rampant caries.
- Documentation supporting only one virgin abutment tooth; at least one tooth must require a crown unless a Maryland Bridge is being considered.
- Tooth Identification (TID) System noting only permanent teeth.
- Documentation supporting that a removable partial is not a viable option to fill the space between the teeth.
Prior authorization will not be given when films show two abutment teeth (virgin teeth do not require a crown, except for Maryland Bridge) or there is untreated periodontal or endodontic disease, or rampant caries which would contraindicate the treatment.


Removable prosthodontics (procedure codes D5951, D5952, D5953, D5954, D5955, D5958, D5959, and D5960) for clients with cleft lip or cleft palate requires prior authorization with a completed THSteps Dental Mandatory Prior Authorization Request Form and narrative documenting the medical need for these appliances. Additional information may be requested by the TMHP Dental Director if necessary before making a determination.

The prior authorization number is required on claims for processing. If the client is not eligible for Medicaid on the DOS or the claim is incomplete, it will affect reimbursement. Prior authorization is a condition for reimbursement; it is not a guarantee of payment.

Note: Post-treatment authorization will not be approved for codes that require mandatory prior authorization.

Refer to: Form CH.13, “THSteps Dental Mandatory Prior Authorization Request Form” in this handbook.

4.2.32.1 Cone Beam Imaging

Prior authorization is required for procedure codes D0363 and D0367.

Cone beam imaging is used to determine the best course of treatment for cleft palate repair, skeletal anomalies, post-trauma care, implanted or fixed prosthodontics, and orthodontic or orthognathic procedures. Cone beam imaging is limited to initial treatment planning, surgery, and postsurgical follow up.

To obtain prior authorization, a THSteps Dental Mandatory Prior Authorization Request Form must be submitted with documentation supporting medical necessity and appropriateness. Required documentation includes, but is not limited to, the following:

- Presenting conditions
- Medical necessity
- Status of the client’s treatment

4.2.32.2 General Anesthesia for Dental Treatment

Prior authorization is required for the use of general anesthesia while rendering treatment (to include the dental service fee, the anesthesia fee, and facility fee) regardless of place of service. A client must meet the minimum requirement of 22 total points on the Criteria for Dental Therapy Under General Anesthesia form.

Refer to: Subsection 4.2.25.1, “Criteria for Dental Therapy Under General Anesthesia” in this handbook.

In those areas of the state with Medicaid Managed Care, precertification or approval is required from the client’s health maintenance organization (HMO) for anesthesia and facility charges. It is the dental provider’s responsibility to obtain precertification from the client’s HMO or managed care plan for facility and general anesthesia services. A medical checkup prior to a dental procedure requiring general anesthesia is considered an exception to THSteps periodicity. A referral to the client’s primary care physician is not required. Prior authorization is available for exceptions to periodicity. Providers must include all appropriate supporting documentation with the submittal. The criteria for general anesthesia applies only to treatment of clients who are 20 years of age and younger or ICF/ID program clients.
4.2.32.3 Orthodontic Services

Prior authorization is required for all orthodontic services except for rebonding, recementing, or repair, as required, of fixed retainers (procedure code D8693). Providers must maintain documentation of medical necessity in the client’s dental record for rebonding or recementing of fixed retainers.

Orthodontic services do not include any related services outside those listed in this section (e.g., extractions or surgeries); however, all services must be included in the orthodontic treatment plan.

Approved orthodontic treatment plans must be initiated before clients lose Medicaid eligibility or reach 21 years of age, and all active orthodontic treatments must be completed within 36 months of the authorization date. Services cannot be added or approved after eligibility has expired.

Note: If a client reaches 21 years of age or loses Medicaid eligibility before the authorized orthodontic services are completed, reimbursement is provided to complete the orthodontic treatment plan that was authorized and initiated while the client was 20 years of age or younger and eligible for Texas Medicaid as long as the orthodontic treatment plan is completed within the appropriate time frames.

Any non-orthodontic service that is included as part of the treatment plan (extractions or surgeries) must be completed before the client loses eligibility or reaches 21 years of age in order to be reimbursed through Texas Medicaid. Services cannot be added or approved after Texas Medicaid eligibility has expired.

Once prior authorization is obtained, the provider is obligated to advise the client that he or she is able to receive the approved orthodontic service (including monthly orthodontic adjustment visits and retainers) even if the client loses eligibility or reaches his or her 21st birthday.

All requests must be reviewed by the TMHP Dental Director or other state dental contractor’s board-eligible or board-certified orthodontist employee or consultant who is licensed in Texas.

To avoid unnecessary denials, providers must submit correct and complete information, including documentation for medical necessity for the services requested. Providers must maintain documentation of medical necessity in the client’s medical record. Requesting providers may be asked for additional information to clarify or complete a request.

A completed Texas Health Steps (THSteps) Dental Mandatory Prior Authorization Request Form must be signed and dated by the performing dental provider. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates will not be accepted. The completed authorization form must include the procedure codes for all services requested along with a written statement of medical necessity for the proposed orthodontic treatment.

All prior authorization requests for orthodontic services must be accompanied by an attestation from the requesting provider that the provider is either a pediatric dentist or orthodontist.

General dentists who are requesting prior authorization for orthodontic services must attest and maintain documentation of a minimum of 200 hours of continuing dental education specifically in orthodontics within the last 10 years; 8 hours can be online or self-instruction.

Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services; however, documentation must be produced by the dentist during retrospective review. All attestations are subject to compliance review and orthodontic services may be subject to recoupment.

4.2.32.3.1 Initial Orthodontic Services Request

The prior authorization form must include all of the procedures that are required to complete the requested treatment including, but not limited to, the following:

- Diagnostic workup
- Medically necessary extractions (Tooth ID must be included)
- Orthognathic surgery
- Upper and lower appliance
- Monthly adjustments
- Special orthodontic treatment appliances
- Placement of banding and brackets
- Replacement of brackets
- Removal of the brackets and arch wires
- Other special orthodontic appliances
- Fabrication of special orthodontic appliances
- Delivery of orthodontic retainers
- Appliance removal (if indicated)

A completed and scored Handicapping Labio-Lingual Deviations (HLD) Index with a diagnosis of Angle class (a minimum of 26 points are required for approval of non-cleft palate cases). If attaining a qualifying score of 26 points is uncertain, a brief narrative should be provided.

**Note:** A score of a minimum 26 points on the HLD index does not indicate an automatic approval for comprehensive orthodontics. Approval will be based on the diagnostic workup supporting the HLD index. Documentation provided must be reviewed by a qualified board eligible or board certified orthodontist.

When requesting prior authorization, providers must include diagnostic models, radiographs (X-rays), cephalometric X-ray with tracings, photographs, and other supporting documentation with the THSteps Dental Mandatory Prior Authorization Request Form.

All required documents must be submitted together in one package per prior authorization request. Prior authorization requests that are not submitted in one package per request will be considered incomplete.

**Note:** All documentation submitted with an incomplete request will be sent back to the provider with a letter that indicates the prior authorization request was incomplete. Providers may resubmit prior authorization requests with all the required documentation.

### 4.2.32.3.2 Diagnostic Tools

Prior authorization requests must include the date of service the diagnostic tools were obtained (the date of service the dental records were produced). All diagnostic tools must be properly labeled and protected when shipped by the provider. If any diagnostic tool is damaged during shipment, the provider may be required to reproduce the documentation for consideration of the case for prior authorization.

**Note:** If medical necessity cannot be determined from the diagnostic tools that are submitted with the request, the prior authorization request may be denied.

**Note:** TMHP will be responsible for retaining an image of each diagnostic tool that is submitted for every complete orthodontic prior authorization request.

Copies of diagnostic models, X-rays, and any other paper diagnostic tools will be accepted and are preferred. Copies will not be returned, but providers will be required to maintain the dental records for retrospective review. Originals will be returned to the submitting provider only when the document is clearly marked “original.”

Diagnostic models in the form of plaster casts are preferred; however, providers may choose the positions in which the casts are made. E-models must be in the centric occlusion position.
Radiographs that are submitted must include, but are not limited to, the following:

- Panoramic or a full mouth series
- Cephalometric with tracings

Photographic images must be submitted with the request and must be in a 1:1 ratio format (actual size), including, but not limited to, the following:

- Full face, smiling
- Left and right profiles
- Full maxillary arch (open mouth view)
- Full mandibular arch (open mouth view)
- Right side occluded in centric occlusion
- Left side occluded in centric occlusion
- Anterior occluded in centric occlusion

X-rays must be of diagnostic quality and do not have to be submitted on photographic quality paper. Submitting providers must attest that radiographs, photographs, and other documentation are unaltered.

4.2.32.3.3 Authorization Extensions

Extensions on allowed time frames may be considered no sooner than 60 days before the authorization expires. Extra monthly adjustments (procedure code D8670) will not be prior authorized, but the time frame may be considered for extension not to exceed 36 months of actual treatment. Providers must submit the following:

- Diagnostic workup.
  
  **Note:** Photographs may be substituted for models.

- The reason the treatment was not completed in the original time frame.

- An explanation of the treatment plan status.

4.2.32.3.4 Crossbite Therapy

Requests for crossbite therapy (procedure codes D8050 or D8060) require the submission of diagnostic models to receive authorization. An HLD score sheet is not required for crossbite therapy.

Providers that submit requests for crossbite therapy must maintain documentation in the client’s record that demonstrates the following criteria:

- Posterior teeth—Are not end-to-end, but the buccal cusp of the upper teeth is lingual to the buccal cusp of the lower teeth.

- Anterior teeth—The incisal edge of the upper teeth are lingual to the incisal edge of the opposing arch.

4.2.32.3.5 Minor Treatment to Control Harmful Habits

A THSteps Dental Mandatory Prior Authorization Form must be completed when requesting prior authorization for orthodontic appliances for minor treatment to control harmful habits. Documentation must support medical necessity of any appliance requested.

Providers must submit diagnostic models when requesting prior authorization for a removable appliance or fixed appliance.
Procedure codes D8210 or D8220 may only be approved for control of harmful habits including, but not limited to, thumb sucking or tongue thrusting and may not be prior authorized for services that are related to comprehensive orthodontic services.

4.2.32.3.6 Premature Termination of Orthodontic Services

Prior authorization for the premature termination of orthodontic services (procedure code D8680) is required.

Premature termination of orthodontic services includes all of the following:

- Removal of the brackets and arch wires.
- Other special orthodontic appliances.
- Fabrication of special orthodontic appliances.
- Delivery of orthodontic retainers.

The prior authorization must include all of the following for consideration:

- Panoramic radiograph (copies are preferred).
- Cephalometric radiograph with tracing (copies are preferred).
- Six intra-oral photographs (copies are preferred).
- Three extra-oral photographs (copies are preferred).
- A narrative documenting why the provider is terminating the orthodontic services early.
- Documentation that the parent, legal guardian, or the client, if he or she is 18 years of age or older or an emancipated minor, understands that the provider is terminating the orthodontic services, and the client is no longer eligible for orthodontic services by Texas Medicaid/THSteps.

In addition to the final record, the provider requesting premature termination of orthodontic services must submit a copy of the signed release form that includes the following:

A signature by one of the following:

- The parent
- Legal guardian
- The client, if he or she is 18 years of age or older or an emancipated minor

One of the following statements:

- The client is uncooperative or non-compliant with the treating dentist's directions and does not intend to complete orthodontic treatment.
- The client requested the premature removal of orthodontic appliances and does not intend to complete orthodontic treatment.

**Note:** A client for whom removal of an appliance has occurred due to the client's request, or is uncooperative or non-compliant will not be eligible for any additional Medicaid orthodontic services.

- The client has requested the premature removal of orthodontic appliances due to extenuating circumstances including, but not limited to, the following:
  - Incarceration.
  - Mental health complications with a recommendation from the treating physician.
  - Foster care placement.
  - Child of a migrant farm worker. With the intent to complete orthodontic treatment at a later date if Medicaid eligibility for orthodontic services continues.
- Special medical conditions.

**Note:** If comprehensive orthodontic services are terminated due to extenuating circumstances, clients will be eligible for completion of their Medicaid orthodontic services if the services are re-initiated while the client is eligible for Medicaid.

The requesting provider will be responsible for removal of the orthodontic appliances, final records, and fabrication and delivery of orthodontic retainers at the time of premature removal or at any future time should the client present to the treating provider’s office.

### 4.2.32.3.7 Transfer of Services

Prior authorization that is issued to a provider for orthodontic services is not transferable to another provider. The new provider must request a new prior authorization to complete the orthodontic treatment that was initiated by the original provider. The original prior authorization will be end-dated when services are transferred to another provider.

The new provider must obtain his or her own records, and the new request for orthodontic services must include the date of service on which the documentation was obtained (the date of service on which the records were produced) and the following supporting documentation:

- All of the documentation that is required for the original request

  **Note:** Photographs may be substituted for models.

- The reason the client left the previous provider

- An explanation of the treatment status

The authorization request for clients who are undergoing orthodontic treatment services and subsequently become eligible for Medicaid are subject to the same requirements.

### 4.2.32.3.8 Orthodontic Cases Initiated Through a Private Arrangement

Authorization may be given for continuation of orthodontic cases for clients who initiated orthodontic treatment through a private arrangement before becoming eligible for Medicaid.

Authorization will not be given for continuation of orthodontic cases for clients who initiated orthodontic treatment through a private arrangement and were eligible for Medicaid at the start of service.

### 4.2.33 THSteps and ICF/ID Dental Prior Authorization

Submit claims, dental correspondence, and THSteps and ICF/ID prior authorization requests to the appropriate address listed in the table below:

<table>
<thead>
<tr>
<th>Correspondence</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA dental claim forms</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>PO Box 200555</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0555</td>
</tr>
<tr>
<td>All dental correspondence Prior authorization requests</td>
<td>Texas Medicaid &amp; Healthcare Partnership Fee-for-Service and ICF/ID Dental Authorizations</td>
</tr>
<tr>
<td></td>
<td>PO Box 204206</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-4206</td>
</tr>
</tbody>
</table>

### 4.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including dental services. Dental services are subject to retrospective review and recoupment if documentation does not support the service submitted for payment.
The provider must educate all staff members, including dentists, about the following documentation requirements and charting procedures:

- For THSteps and ICF/ID dental claims, providers are not required to submit preoperative and postoperative radiographs unless these are specifically requested by HHSC, the TMHP Dental Director, or are needed for prior authorization or pre-payment review.

- Documentation of all restorative, operative, crown and bridge, and fixed and removable prosthodontics procedures must support the services that were performed and must demonstrate medical necessity that meets the professional standards of health care that are recognized by TSBDE. Documentation must include appropriate pretreatment, precementation and postcementation radiographs, study models and working casts, laboratory prescriptions, and invoices. Documentation must include the correct DOS. A panoramic radiograph without additional bitewing radiographs is considered inadequate as a diagnostic tool for caries detection. OIG may retrospectively recoup payment if the documentation does not support the services submitted for payment.

- All documentation must be maintained in the client’s record for a period of five years to support the medical necessity at the time of any post-payment utilization review. All documentation, including radiographs, must be of diagnostic and appropriate quality.

- In any situation where radiographs are required but cannot be obtained, intraoral photographs must be in the chart.

- Any complications, unusual circumstances encountered, morbidity, and mortality must be entered as a complete narrative in the client’s record.

- A provider must maintain a minimum standard of care through appropriate and adequate records, including a current history, limited physical examination, diagnosis, treatment plan, and written informed consent as a reasonable and prudent dentist would maintain. These records, as well as the actual treatment, must be in compliance with all state statutes, the Dental Practice Act, and the TSBDE Rules.

- Documentation for endodontic therapy must include the following: the medical necessity, pretreatment, during treatment, and post-treatment periapical radiographs, the final size of the file to which the canal was enlarged, and the type of filling material used. Any reason that the root canal may appear radiographically unacceptable must be entered in the chart. Endodontic therapy must be in compliance with the American Association of Endodontists quality assurance guidelines.

- Documentation for most periodontal services requires a six-point per tooth depth of pocket charting, a complete mouth series of periapical and bitewing radiographs, and any other narratives or supporting documentation consistent with the nationally accepted standards of care of the specialty of periodontics, and which conform to the minimum standard of care for periodontal treatment required of Texas dentists. A panoramic radiograph without additional bitewing or periapical radiographs is considered inadequate for diagnosis of periodontal problems.

- Documentation for surgical procedures requiring a definitive diagnosis for submitting a claim for a specific CDT code necessitates that a pathology report and a written record of clinical observations be present in the chart, together with any appropriate radiographs, operative reports, and appropriate supporting documentation. All impactions, surgical extractions, and residual tooth root extractions require appropriate preoperative periapical or panoramic radiographs (subject to limitations) be present in the chart.

- Any documentation requirements or limitations not mentioned in this manual that are present in the CDT are applicable. The written documentation requirements or limitations in this manual supercede those in the CDT.
4.3.1 General Anesthesia

The dental provider is required to maintain the following documentation in the client’s dental record:

- The medical evaluation justifying the need for anesthesia
- Description of relevant behavior and reference scale
- Other relevant narratives justifying the need for general anesthesia
- Client’s demographics, including date of birth
- Relevant dental and medical history
- Dental radiographs, intraoral/perioral photography, or diagram of dental pathology
- Proposed dental plan of care
- Consent signed by parent or guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained
- Completed Criteria for Dental Therapy Under General Anesthesia form
- The parent or guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist’s assessment of their child’s behavior
- Dentist’s attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand alone form

4.3.2 Orthodontic Services

Requests for orthodontic services must be accompanied by all of the following documentation:

- An orthodontic treatment plan. The treatment plan must include all procedures required to complete full treatment (e.g., extractions, orthognathic surgery, upper and lower appliance, monthly adjustments, anticipated bracket replacements, appliance removal if indicated, special orthodontic appliances). The treatment plan should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch are reviewed for duplication of purpose.
- Diagnostic models.
- Cephalometric radiograph with tracings.
- Completed and scored HLD sheet with diagnosis of Angle class (a minimum of 26 points is required for consideration of approval of non cleft palate cases).
- Facial photographs.
- Full series of radiographs or a panoramic radiograph; diagnostic-quality films are required (copies are preferred and will not be returned to the provider).
- Any additional pertinent information as determined by the dentist or requested by TMHP’s Dental Director. Requests for crossbite therapy require the submission of diagnostic models to receive authorization. Providers must maintain documentation in the client’s record that demonstrates the following criteria:
  - Posterior teeth. Not end-to-end, but buccal cusp of upper teeth should be lingual to buccal cusp of lower teeth.
  - Anterior teeth. The incisal edge of upper should be lingual to the incisal of the opposing arch.

The dentist should be certain that radiographs, photographs, and other information are properly packaged to avoid damage. TMHP is not responsible for lost or damaged materials.
Refer to: Form CH.13, “THSteps Dental Mandatory Prior Authorization Request Form” in this handbook.

4.4 Utilization Review
HHSC or a designated entity may conduct utilization reviews through automated analysis of a provider’s pattern(s) of practice, including peer group analysis. Such analysis may result in a subsequent on-site utilization review. HHSC or its claims processing contractor may conduct utilization reviews at the direction of the Office of Inspector General (OIG), according to HHSC rules.

DSHS may also conduct dental utilization reviews of randomly selected THSteps dental providers. These reviews compare Medicaid dental services that have been reimbursed to a dental provider to the results of an oral examination of the client as conducted by DSHS regional dentists.

Refer to: 25 TAC, §33.72 for more information about utilization review.

4.5 Claims Filing and Reimbursement

4.5.1 Reimbursement
The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §§355.455(b), 355.8081, 355.8085, and 355.8441(11). Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The 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.

4.5.2 Third Party Resources (TPR)
For THSteps and ICF/ID dental claims, TMHP is responsible for determining if a TPR exists and for recouping payment from the TPR.

THSteps providers are not required to bill other insurance before billing Medicaid. If the provider is aware of other insurance, however, the provider must choose whether or not to bill the other insurance.

The provider has the following options:

- If the provider chooses to bill the other insurance, the provider must submit the claim to the client’s other insurance before submitting the claim to Medicaid.

- If the provider chooses to bill Medicaid and not the client’s other insurance, the provider is indicating that he or she accepts the Medicaid payment as payment in full. Medicaid then has the right to recovery from the other insurance. The provider does not have the right to recovery and cannot seek reimbursement from the other insurance after Medicaid has made payment.

- If the provider learns that a client has other insurance coverage after Medicaid has paid a claim, the provider must refund the payment to Medicaid before billing the other insurance.

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

4.5.3 Claim Submission After Loss of Eligibility
The Texas Medicaid 95-day filing deadline applies to all THSteps and ICF/ID dental services. If a client has lost Medicaid eligibility or turned 21 years of age, continue to file claims for services provided on the DOS the client was eligible. Indicate the actual DOS on the claim form, and enter the authorization number in the appropriate block on each claim filed.

4.5.4 Claims Information

Dental services must be submitted to TMHP in an approved electronic format or on the ADA Dental Claim Form. Providers may purchase ADA Dental claim forms from the vendor of their choice. TMHP does not supply the forms. A sample of the ADA Dental Claim form can be found on the ADA website at www.ada.org/7119.aspx.

When completing an ADA Dental claim form, all required information must be included on the claim, as TMHP does not key information from attachments. Superbills or itemized statements are not accepted as claim supplements.

All THSteps and ICF/ID claims must be received by TMHP within 95 days from each DOS and submitted to the following address:

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

Claims for emergency, orthodontic, or routine dental services must each be filed on separate forms. A claim submitted for either emergency or orthodontic services must be identified as such in Block 35 (Remarks) of the claim form.

A THSteps and ICF/ID dental provider cannot submit claims to Texas Medicaid under his individual performing provider identifier for the services provided by one or more associate dentists practicing in his office as employees or independent contractors with specific employer-employee or contractual relationships. All dentists providing services to Medicaid clients must enroll as THSteps dental providers regardless of employer relationships. The individual provider submitting claims may be reimbursed into a single accounting office to maintain these described relationships.

Claims submitted by newly-enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the DOS.

Providers should submit claims to Texas Medicaid for their usual and customary fees.

Claims for dental services provided to children in foster care must be filed with DentaQuest, the dental claims processor for Superior HealthPlan.

Refer to: Subsection 4.2.5.2, “Children in Foster Care” in this handbook.

Claims must not be submitted to Texas Medicaid for appointments missed by clients. A client with Medicaid cannot be billed for failure to keep an appointment. Only claims for actual services rendered are considered for payment.

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

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

Subsection 1.6.9, “Billing Clients” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

4.5.5 Claim Appeals

A claim denied because of age restrictions or other limitations listed in the Medicaid dental fee schedule may be considered for reimbursement on appeal when client medical necessity is provided to the TMHP Dental Director.

All denied claim appeals (see Section 7: Appeals [Vol. 1, General Information]) must be submitted to TMHP with the exception of a request to waive late filing deadlines. TMHP does not have the authority to waive state or federal mandates regarding claim filing deadlines.
If, after all appeal processes at TMHP have been exhausted, the provider remains dissatisfied with TMHP’s decision concerning the appeal, the provider may file a complaint with the HHSC Claims Administrator Contract Management Unit.

Refer to: Subsection 7.3.1, “Administrative Claim Appeals” in Section 7, “Appeals” (Vol. 1, General Information).

Note: Providers must exhaust the appeals process with TMHP before filing a complaint to the HHSC Claims Administrator Contract Management Unit.

Refer to: Subsection 7.1.5, “Paper Appeals” in Section 7, “Appeals” (Vol. 1, General Information).

Providers may use one of three methods to appeal Medicaid claims to TMHP: telephone (AIS), paper, or electronic.

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

Certain claims must be appealed on paper; they cannot be appealed either electronically or by telephone.

Refer to: Subsection 7.1.5, “Paper Appeals” in Section 7, “Appeals” (Vol. 1, General Information) for information about appeals that may not be appealed electronically and claims that may not be appealed through AIS.

To appeal in writing:

If a claim cannot be appealed electronically or by telephone, appeal the claim on paper by completing the following steps:

1) Provide a copy of the R&S Report page where the claim is reported.

2) Circle one claim per R&S Report page.

3) Identify the information that was incorrectly provided and note the correct information that should be used to appeal the claim. If necessary, specify the reason for appealing the claim.

4) Attach radiographs or other necessary supporting documentation.

5) If available, attach a copy of the original claim. Claim copies are helpful when the appeal involves dental policy or procedure coding issues.

6) Do not copy supporting documentation on the opposite side of the R&S Report.

7) It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It is also recommended that paper documentation be sent via certified mail with a return receipt requested to establish TMHP’s receipt of the claim and the date the claim was received. The provider is urged to retain copies of multiple claim submissions if the Medicaid provider identifier is pending.

   Note: Claims submitted by newly-enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the DOS.

8) Submit the paper appeal with supporting documentation and any radiographs and adjustment requests to the following address:

Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
To appeal by telephone:

1) Contact the Dental Line at 1-800-568-2460.
2) For each claim in question, have the R&S Report listing the claim and any supporting documents readily available.
3) Identify the claim submitted for appeal. The internal control number (ICN) will be requested.
4) Supply the information necessary to correct the claim, such as the missing tooth number or letter, the corrected procedure code, surface ID, or Medicaid number.

The appeal will appear as finalized or pending on the following week’s R&S Report.

Providers may also appeal electronically.

Electronic appeal submission is a method of submitting Texas Medicaid appeals using a personal computer. The electronic appeals feature can be accessed directly through the TMHP EDI Gateway or by using TexMedConnect. For additional information, contact the TMHP EDI Help Desk at 1-888-863-3638.

Electronic appeals can increase accuracy of claims processing, resulting in a more efficient case flow to the provider:

- Download and printout capabilities help maintain audit trails for the provider.
- Appeal submission windows can be automatically filled in with electronic R&S Report information, thereby reducing data entry time.

4.5.6 Frequently Asked Questions About Dental Claims

Q Why is routine dental treatment not a benefit when performed at the same visit as an emergency visit?
A The following are reasons routine dental treatment is not a benefit when performed at the same visit as an emergency visit:

- The purpose of an emergency claim is to allow the provider to treat a true emergency without the concern that routine dental procedures may be denied.
- Medicaid program policy guidelines do not allow payment for both emergency and routine services to the same provider at the same visit. True emergency claims process through the audit system correctly when “emergency” is checked on either the paper or electronic claim and the Remarks or Narrative section of the claim form describes the nature of the emergency.

Q Why are some claims for oral exams and emergency exams on the same date for the same client denied?
A Medicaid program policy does not allow claims for an initial oral exam and an emergency exam to be submitted for the same DOS for the same client. An emergency exam performed by the same provider in the same six-month time period as an initial exam may be considered for reimbursement only when the claim for the emergency exam indicates it is an emergency and the emergency block is marked and the Remarks or Narrative section is completed. If the claim is not marked as an emergency, the claim will be denied.

Q How are orthodontic bracket replacements reimbursed? Can the client be charged for bracket replacements?
A The provider must use orthodontic procedure code D8690 to claim reimbursement for bracket replacement. Medical necessity must be documented in the client record. Payment is subject to retrospective review. The client with current Medicaid eligibility must not be charged for bracket replacement. If the provider charges the client erroneously, the provider must refund any amount paid by the client.
Q  Why could an appeal of a denied claim take a long time?
A  An appeal can take a long time if TMHP is required to research the denied claim and determine the reason the claim did not go through the system. For faster results, providers should submit appeals as soon as possible and not use the entire 120 days allowed to submit the appeal.

The following are guidelines on filing claims efficiently:

- Use R&S Report dates to track filed claims.
- File claims electronically through TMHP EDI. Electronic claims submission does not allow a claim with an incorrect date to be accepted and processed, which saves time for the provider submitting claims and TMHP in processing claims. Call 1-888-863-3638, for more information about TMHP EDI.
- File claims with the correct information included. Most denied claims result from the omission of dates, signature, or narrative, or incorrect ID numbers such as client Medicaid numbers or provider identifiers.

Q  Why are only ten appeals allowed per call?
A  There is a limit on appeals per call to allow all providers equal access.

Q  Why do reimbursement checks sometimes take a long time to arrive?
A  Reimbursement may be delayed if a provider fails to submit claims in a timely manner.

Q  Does electronic claims submission result in delayed payment?
A  No. Providers who submit claims electronically report faster results than when submitting claims on paper. Providers are encouraged to use TMHP EDI for claims submission.

The following are helpful hints to a more efficiently processed claim:

- Ensure the provider identifier is on all claims.
- Include the performing provider’s signature on all paper claims.
- Verify client eligibility for procedures.
- Verify if the procedure code requires a narrative on the claim; the narrative is for medical necessity.
- Include the required client information, including name, birth date, and client number.
- Dental auxiliary staff (i.e., the hygienist or the chairside assistant) cannot enroll in Texas Medicaid; therefore, they cannot submit claims to Texas Medicaid. Any procedure performed by the auxiliary must be submitted by the supervising dentist, using the dentist’s provider identifier.

Claim Submission Reminders:

- Procedure code D8660 is allowed at different age levels, per provider. If a claim for procedure code D8660 is submitted within six months of procedure code D8080, procedure code D8080 will be reduced by the amount that was paid for procedure code D8660.
- Prior authorization is required with documentation of medical necessity when replacing lost or broken orthodontic retainers (procedure code D8680). Clients may not be billed for covered services.
- Prior authorization of orthodontic services is nontransferable. If a client changes an orthodontic provider for any reason, or a provider ceases to be a Medicaid provider, the new orthodontic services provider must submit a separate request for prior authorization. The provider requesting and receiving authorization for the service also must perform the service and submit the claim. Codes listed on the authorization letters are the only codes considered for payment. All other codes submitted for payment are denied. Providing the authorization number on the submitted claim results in more efficient claims processing.
• General anesthesia (provided in the dentist office, ambulatory service clinic, and inpatient/outpatient hospital settings) does not require prior authorization, unless the client does not meet the minimum required points for general anesthesia in subsection 4.2.25.1, “Criteria for Dental Therapy Under General Anesthesia” in this handbook. All THSteps dental charts for dental general anesthesia are subject to retrospective, random review for compliance with the Criteria for Dental Therapy Under General Anesthesia and requirements for chart documentation.

• Providers must not bill a client unless a formal denial for the requested item or service has been issued by TMHP stating the service is not a benefit of Texas Medicaid and the client has signed the Client Acknowledgment Statement in advance of the service being provided for that specific item or service. A provider must not bill Medicaid clients if the provided service is a benefit of Texas Medicaid.

Refer to:  Subsection 1.6.9.1, “Client Acknowledgment Statement” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

THSteps clients must receive:

• Dental services specified in the treatment plan that meet the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.

• Dental services that are free from abuse or harm from the provider or the provider’s staff.

• Only the treatment required to address documented medical necessity that meets professionally recognized standards of health care.

5. THSTEPS MEDICAL

5.1 THSteps Medical and Dental Administrative Information

5.1.1 Overview

This section describes the administrative requirements for THSteps, including provider requirements, client eligibility requirements, and billing and claims processing information. Providers that need additional information may call 1-800-757-5691 or refer to Appendix F: THSteps Quick Reference Guide in this handbook for a more specific list of resources and telephone numbers. Providers may also contact the Texas Department of State Health Services (DSHS) THSteps Provider Relations staff located in DSHS regional offices by calling the appropriate regional office as listed in Appendix A: State and Federal Offices Communication Guide (Vol. 1, General Information). THSteps Provider Relations contact information is also available on the DSHS website at www.dshs.state.tx.us/thsteps/regions.shtml. In addition, THSteps has developed online educational modules to provide additional information about the program, components of the medical checkup, and other information. These modules provide free continuing education hours for a variety of providers. Providers do not have to be enrolled in THSteps. These courses may be accessed at www.txhealthsteps.com.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid’s comprehensive preventive child health service for clients who are birth through 20 years of age. In Texas, EPSDT is known as THSteps and includes periodic screening, vision, hearing, and dental preventive and treatment services. EPSDT was created by the 1967 amendments to the federal Social Security Act and defined by the Omnibus Budget Reconciliation Act (OBRA) of 1989. The periodic screening for a checkup consists of five federally required components as noted on the THSteps Periodicity Schedule. In addition, Section 1905(r)(5) of the Social Security Act (SSA) requires that any medically necessary health-care service listed in the Act be provided to EPSDT clients even if the service is not available under the state’s Medicaid plan to the rest of the Medicaid population. A service is medically necessary
when it corrects or ameliorates the client’s disability, physical or mental illness, or chronic condition. These additional services are available through CCP. For questions about coverage, providers can call CCP at 1-800-846-7470.

5.1.2 Statutory Requirements
Several specific legislative requirements affect THSteps and the providers participating in the program. These include, but are not limited to, the following:

- Newborn Screening, Health and Safety Code, Chapter 33, Section §33.011 Newborn Screening Test Requirement.
- Requirements for Reporting Abuse or Neglect, as outlined in subsection 1.6.1, “Compliance with Texas Family Code” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).
- Early Childhood Intervention (ECI), 34 Code of Federal Regulations (CFR) Part 303; Chapter 73, Texas Human Resources Code, and Title 40 TAC, Chapter 108.
- Newborn Hearing Screening, Health and Safety Code, Chapter 47.
- Teen Confidentiality Issues. There are many state statutes that may affect consent to medical care for a minor, depending on the facts of the situation. Among the relevant statutes are Chapters 32, 33, 153, and 266 of the Texas Family Code. Providers may want to consult an attorney, their licensing board, or professional organization if guidance is needed or questions arise on matters of medical consent.

Refer to: Appendix D: Texas Health Steps Statutory State Requirements of this handbook for more information.

5.1.3 Texas Vaccines for Children (TVFC) Program
The TVFC program provides vaccines at no cost to the provider. The vaccines are recommended according to the Recommended Childhood and Adolescent Immunization Schedule (Advisory Committee on Immunization Practices [ACIP], AAP, and the American Academy of Family Physicians [AAFP]). Medicaid does not reimburse for vaccines/toxoids that are available from TVFC. THSteps providers must enroll in TVFC at DSHS to obtain free vaccines for clients who are birth through 18 years of age. Providers may not charge Texas Medicaid for the cost of the vaccines obtained from TVFC; however the administration fee, not to exceed $22.06, is considered for reimbursement.

When single antigen vaccine(s)/toxoid(s) or comparable antigen vaccine(s)/toxoid(s) are available for distribution through TVFC, but the provider chooses to use an ACIP-recommended product that is not distributed through TVFC, the vaccine/toxoid will not be covered; however, the administration fee will be considered.

Note: Administered vaccines/toxoids must be reported to DSHS. DSHS submits all vaccines/toxoids reported with parental consent to a centralized repository of immunization histories for clients younger than 18 years of age. This repository is known in Texas as ImmTrac.

For additional information about immunizations, providers can refer to the THSteps online educational module “Immunization” at www.txhealthsteps.com.

Refer to: Appendix B: Immunizations in this handbook.

Form CH.40, “TVFC Provider Enrollment (3 Pages)” in Appendix A, “THSteps Forms,” in this handbook for more information about enrolling as a TVFC provider.
5.1.4 Vaccine Adverse Event Reporting System (VAERS)

The National Childhood Vaccine Injury Act (NCVIA) of 1986 requires health-care providers to report:

- Any reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the Reportable Events Table that occurs within the specified time period after vaccination.

NCVIA requires health-care providers to report certain adverse events that occur following vaccination. As a result, VAERS was established by CDC and FDA in 1990. VAERS provides a mechanism for the collection and analysis of adverse events (side effects) associated with vaccines currently licensed in the United States. Adverse events are defined as health effects that occur after immunization that may or may not be related to the vaccine. VAERS data are monitored continually to detect unknown adverse events or increases in known side effects.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from www.dshs.state.tx.us/immunize/forms/vaers_table.pdf.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event. For additional information about NCVIA, providers can refer to www.dshs.state.tx.us/immunize/forms/11-11246.

5.1.5 Referrals for Medicaid-Covered Services

When a provider performing a checkup determines that a referral for diagnosis or treatment is necessary for a condition found during the medical checkup, that information must be discussed with the parents or guardians. A referral must be made to a provider who is qualified to perform the necessary diagnosis or treatment services. If the performing provider is competent to treat the condition found, a referral elsewhere is not necessary, unless it is to the primary care provider to assure continuity of care.

Providers that need assistance finding a specialist who accepts clients with Medicaid coverage can call the THSteps toll-free helpline at 1-877-847-8377, or they can find one using the Online Provider Lookup on the TMHP website at www.tmhp.com.

Continuity of care is an important aspect of providing services and follow-up. Efforts should be made to determine that the appointment was kept and that the provider who received the referral has provided a diagnosis and recommendations for further care to the referring provider.

In addition to referrals for conditions discovered during a checkup or for specialized care, the following referrals may be used:


- **Hearing Services referrals.** If the hearing screening returns abnormal results, clients who are birth through 20 years of age must be referred to a Texas Medicaid provider who is an audiologist or physician who is experienced with the pediatric population and who offers auditory services.

- **Routine Dental Referrals.** The provider must refer clients to establish a dental home beginning at 6 months of age or earlier if trauma or early childhood caries are identified. For established clients after the 6-month medical checkup visit, the provider must confirm if a dental home has been established and is ongoing; if not, additional referrals must be made at subsequent medical checkups until the parent or caregiver confirms that a dental home has been established for the client. Clients who
are birth through 5 months of age are not eligible for routine dental checkups but should be referred
to a dentist if any dental issues are identified during a THSteps medical checkup visit or acute care
visit. When possible, clients should be referred to a provider who has completed the required benefit
education and is certified by the DSHS Oral Health Program to perform First Dental Home services.
The First Dental Home provider may be located through the advanced search function in the Online
Provider Look Up or by calling 1-877-847-8377.

- **Referrals for Dental Treatment.** If a THSteps medical provider identifies the medical necessity of
dental services, the provider must refer the client to a THSteps dental provider. The THSteps
medical provider can accomplish this by providing the parent or guardian a listing of THSteps
dentists from the Online Provider Lookup. The parent or guardian can receive assistance in locating
a THSteps dentist and assistance with scheduling of dental appointments by contacting the THSteps
toll-free helpline at 1-877-847-8377. Clients who are birth through 5 months of age also can be seen
for emergency dental services by the dentist at any time for trauma, early childhood caries, or other
oral health problems. Clients who are birth through 20 years of age may self-refer for dental care.

- **Emergency Dental Referrals.** If a medical checkup provider identifies an emergency need for dental
services, such as bleeding, infection, or excessive pain, the client may be referred directly to a particip-
ating dental provider. Emergency dental services are covered at any time for all Medicaid clients
who are birth through 20 years of age.

  **Note:** Assistance in coordinating dental referrals can be obtained from the THSteps toll-free
helpline at 1-877-847-8377 or the DSHS Regional THSteps Coordinator for the respective
region (lists are provided in Appendix A: State and Federal Offices Communication Guide
(Vol. 1, General Information). In cases of both emergency and nonemergency dental services,
clients are able to make a choice when selecting a dental provider who is participating in the
THSteps Dental Program.

- **Family Planning and Genetic Services Referrals.** For clients eligible for Medicaid who need genetic
services or family planning services, a referral should be made. Information about Medicaid-
covered genetic services is available in the Medical and Nursing Specialists, Physicians, and Physician
Assistants Handbook (Vol. 2, Provider Handbooks) and information about family planning services
is available in Section 2, “Medicaid Title XIX family planning services” in the Gynecological and
Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks). If a
THSteps medical provider also provides family planning, the provider may inform clients that these
services are available.

- **ECI Referrals.** Federal and state law requires providers to refer children as soon as possible, but no
longer than 7 days after identification of a suspected developmental delay or disability to the local
ECI program for children who are birth through 35 months of age regardless if a referral was made
to another qualified provider. The provider may call the local ECI Program or the DARS Inquiries
Line at 1-800-628-5115 to make referrals. Children who are 3 years of age and older with a suspected
developmental delay or disability should be referred to the local school district.

- **WIC Referrals.** Clients who are birth through 5 years of age or who are pregnant are eligible for WIC
and should be referred to WIC for nutrition education and counseling, and food benefits.

  **Refer to:** Section 1, “General Information” in the Medicaid Managed Care Handbook (Vol. 2,
Provider Handbooks) for more information about referrals.

### 5.1.6 THSteps Medical Checkup Facilities

All THSteps medical checkup policies apply to checkups completed in a physician’s office, a health
department, clinic setting, or in a mobile/satellite unit. Enrollment of a mobile/satellite unit must be
under a physician or clinic name. Mobile units can be a van or any area away from the primary office
and are considered extensions of that office and are not separate entities.

The physical setting must be appropriate so that all elements of the checkup can be completed.
Refer to: Subsection 5.3.10, “THSteps Medical Checkups Periodicity Schedule” in Section 5 of this handbook for information on the THSteps Periodicity Schedule.

Subsection 5.3.11, “Mandated Components” in Section 5 of this handbook for additional information on checkup components.

5.1.7 THSteps Dental Services
Access to THSteps dental services is mandated by Texas Medicaid and provides reimbursement for the early detection and treatment of dental health problems, including oral health preventive services, for Medicaid clients who are birth through 20 years of age. THSteps dental service standards are designed to meet federal regulations and to incorporate the recommendations of representatives of national and state dental professional groups.

OBRA 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which FFP is available, regardless of the limitations of Texas Medicaid. This expansion is referred to as CCP.

Refer to: Section 2, “Medicaid Children’s Services Comprehensive Care Program (CCP)” in this handbook for more information.

THSteps-designated staff (HHSC, DSHS, or its designee), through outreach and education, encourage the parents or caregivers of eligible clients to use THSteps dental checkups and preventive care when clients first become eligible for Medicaid and each time clients are due for their next periodic dental checkup.

Upon request, THSteps-designated staff (HHSC, DSHS, or its designee) assist the parents or caregivers of eligible clients with scheduling appointments and transportation. Medicaid clients have freedom of choice of providers and are given names of enrolled providers. Call the THSteps toll-free helpline at 1-877-847-8377 for a list of THSteps dental providers in a specific area.

For additional information about dental health, providers can refer to the THSteps online educational modules “Oral Health For Primary Care Providers” and “Oral Health Examinations for Dental Professionals” at www.txhealthsteps.com.

5.2 Enrollment

5.2.1 THSteps Medical Provider Enrollment
Providers cannot be enrolled if their professional license is due to expire within 30 days of application. Facility providers must submit a current copy of the supervising practitioner’s license. To provide Medicaid services, each NP or CNS must be licensed as an RN and be recognized as an APRN by Texas BON.

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

The following provider types may provide THSteps preventive services within his or her scope of practice and must also be enrolled in Texas Medicaid and as a THSteps provider:

- A physician (doctor of medicine [M.D.] or doctor of osteopathy [D.O.]) or physician group
- A physician assistant (PA)
- A clinical nurse specialist (CNS)
- A nurse practitioner (NP)
- A certified nurse midwife (CNM)
- A federal qualified health center (FQHC)
- A rural health clinic (RHC)
• A health-care provider or facility with physician supervision including, but not limited to:
  • Community-based hospital and clinic
  • Family planning clinic
  • Home health agency
  • Local or regional health department
  • Maternity clinic
  • Migrant health center
  • School-based health center

**Medical Residents** – Medical residents may provide medical checkups in a teaching facility under the guidance of the attending staff as long as the facility’s medical staff by-laws and requirements of the Graduate Medical Education (GME) Program are met, and the attending physician has determined the intern or resident to be competent to perform checkups. THSteps does not require the supervising physician to examine the client as long as these conditions are met.

**Clinics** – In a clinic, a physician is not required to be present at all times during the hours of operation unless otherwise required by federal regulations. A physician must assume responsibility for the clinic’s operation.

### 5.2.1.1 Requirements for Registered Nurses Who Provide Medical Checkups

RNs without a CNS, NP, or CNM recognition as an APRN by the Texas BON may provide medical checkups only under direct physician supervision, meaning the physician is either on site during the checkup or immediately available to furnish assistance and direction to the RN during the checkup.

Required online education modules developed by THSteps must be completed prior to providing checkup services. All modules are approved for continuing education units (CEUs) for RNS as well as other medical disciplines. Required THSteps online education modules may be accessed at www.txhealthsteps.com. The RN or the RN’s employer must maintain documentation that the required modules were completed. Required modules include:

• Adolescent Health Screening
• Behavioral Health: Screening and Intervention
• Case Management Services in Texas
• Cultural Competence
• Developmental Surveillance and Screening
• Hearing and Vision Screening
• Immunization
• Introduction to the Medical Home
• Management of Overweight and Obesity in Children and Adolescents
• Newborn Hearing Screening
• Newborn Screening
• Nutrition
• Oral Health for Primary Care Providers
• Texas Health Steps: Overview
• Texas Medicaid Services for Children
• Using Developmental Screening Tools

Online modules are updated regularly to include new content. RNs that have completed the required modules previously are encouraged, but not required to retake online modules.

Before a physician delegates a THSteps checkup to an RN, the physician must establish the RN’s competency to perform the service as required by the physician’s scope of practice. The delegating physician is responsible for supervising the RN who performs the services. The delegating physician remains responsible for any service provided to a client.

Refer to: Subsection 5.2.1, “THSteps Medical Provider Enrollment” in this handbook for more information about enrollment procedures.

5.3 Services, Benefits, Limitations, and Prior Authorization

5.3.1 Eligibility for THSteps Services and Checkup Due Dates

Through outreach, THSteps staff (DSHS, HHSC, or contractors) encourage clients to use THSteps preventive medical checkup services when they first become eligible for Medicaid and each time thereafter when they are periodically due for their next medical checkup. THSteps will send clients a letter when they are due for a medical checkup.

A client is eligible for THSteps services, including medical checkups, from birth through 20 years of age. The following applies:

- If the client turns 21 on the first day of the month, the client is no longer eligible for THSteps services.
- If the client turns 21 on the second day of the month or later, the client is eligible for THSteps services through the end of the month.

Although the Medicaid Eligibility Verification Letter (Form H1027) identifies eligible clients when the client’s Your Texas Benefits Medicaid card is lost or has not yet been issued, Form H1027 does not indicate if the client is due for medical checkup services. Providers can verify the client’s eligibility through www.YourTexasBenefitsCard.com, TexMedConnect, or the TMHP Contact Center.

A client is due for a THSteps medical checkup based on his or her date of birth and the ages indicated on the periodicity schedule. Children younger than three years of age are due at frequent intervals. Children and youth three years of age and older are considered due for a checkup on their birthday and are encouraged to have a yearly checkup as soon as practical. In addition, for children enrolled in Medicaid managed care, a new member is due for a THSteps medical checkup as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 90 days of enrollment for all other eligible child members.

Managed care organizations are also required to assure existing members of their health plan eligibility requirements to receive timely medical checkups. A checkup for an existing member from birth through 35 months of age is timely if received within 60 days beyond the periodic due date based on the client’s birth date. For existing members 36 months of age and older, a checkup is due beginning on the child’s birthday and is considered timely if it occurs within 364 calendar days after the child’s birthday in a non-leap year or 365 days after the child’s birthday in a leap year. Checkups received before the periodic due date are not reportable as timely medical checkups. Providers should contact the appropriate MCO for further details.

Providers should schedule checkups based on the ages in the periodicity schedule, but circumstances may support the need for a checkup prior to the client’s birthday (for example, a 4-year checkup could be performed prior to the child’s 4th birthday if the child is a member of a migrant family that is leaving the area). THSteps fee-for-service policy creates this flexibility by allowing a total number of checkups at each age range.

Refer to: “Subsection 5.3.6, “THSteps Medical Checkups” in this handbook for additional details.
Providers are encouraged to notify the client when they are due for the next checkup according to the THSteps periodicity schedule.

A checkup that is necessary more frequently than indicated on the periodicity schedule is considered an exception-to-periodicity.

**Refer to:** Subsection 5.3.7, “Exception-to-Periodicity Checkups” in this handbook for additional details about billing for a checkup performed as an exception-to-periodicity checkup.

### 5.3.2 Prior Authorization

Prior authorization is not required for preventive care medical checkups.

### 5.3.3 Additional Consent Requirements

Additional parental or guardian consent may be required if online or web-based screening tools are used that could result in client data being stored electronically in an outside database other than the provider’s electronic medical record system, or if the data is used for purposes other than THSteps screening. The provider should seek legal advice regarding the need for this consent.

### 5.3.4 Verification of Medical Checkups

The first source of verification that a THSteps medical checkup has occurred is a paid claim or encounter. THSteps encourages providers to file a claim either electronically or on a CMS-1500 paper claim form as soon as possible after the date of service, as the paid claim updates client information. The provider may contact TMHP through the TMHP website at www.tmhp.com or AIS at 1-800-925-9126 to verify that the client is due for a checkup.

A second source of acceptable verification is a physician’s written statement that the checkup occurred. If the provider chooses to give the client written verification, it must include the client’s name, Medicaid ID number, date of the medical checkup, and a notation that a complete THSteps medical checkup was performed.

**Note:** Verification of medical checkups must not be sent to THSteps but must be maintained by the client to be provided as needed by an HHSC eligibility caseworker.

If neither the first nor the secondary source of verification is available, a THSteps outreach worker may contact the provider’s office for verification.

### 5.3.5 Medical Home

HHSC and DSHS encourage the provision of the THSteps medical checkup as part of a medical home. Texas Medicaid defines a medical home as a model of delivering care that is accessible, continuous, comprehensive, family-centered, and coordinated. In providing a medical home for the client, the primary care clinician directs care coordination together with the client or youth and/or family.

Medical checkup providers with mobile units should encourage the families to establish a medical home for their child(ren) and obtain future checkups from their primary care provider.

When a checkup is provided in the home setting, mobile unit, or clinic other than the medical home, it should be in coordination with the medical home and the results must be provided to the medical home as soon as possible.

A mobile unit is an extension of the provider’s office and must be able to provide a complete checkup.

For additional information on the medical home, providers can refer to the “Introduction to the Medical Home” module provided by THSteps at www.txhealthsteps.com.

### 5.3.6 THSteps Medical Checkups

THSteps medical checkups reflect the federal and state requirements for a preventive checkup. Preventive care medical checkups are a benefit of the THSteps program if they are provided by enrolled THSteps providers and all of the required components are completed. An incomplete preventive
medical checkup is not a benefit. The THSteps periodicity schedule specifies screening procedures required at each stage of the client’s life to ensure that health screenings occur at age-appropriate points in a client’s life.

Components of a medical checkup that have an available CPT code are not reimbursed separately on the same day as a medical checkup, with the exception of initial point-of-care blood lead testing, a tuberculin skin test (TST), developmental and autism screening, vaccine administration, and OEFV.

**Note:** *Initial blood lead testing, other than point-of-care, must be sent to the DSHS Laboratory for testing.*

**Reminder:** *Incomplete medical checkups are subject to recoupment unless there is documentation supporting why a component was not completed.*

Sports physical examinations are not a benefit of Texas Medicaid. If the client is due for a THSteps medical checkup and a comprehensive medical checkup is completed, a THSteps medical checkup may be reimbursed and the provider may complete the documentation for the sports physical.

**Refer to:** *The THSteps Medical Checkups Periodicity Schedule which may be found at www.dshs.state.tx.us/thsteps/providers.shtm.*

Checkups should be scheduled, to the extent possible, based on the ages on the periodicity schedule to accommodate the need for flexibility when scheduling checkup appointments.

The following table lists the number of visits allowed at each age range:

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth through 11 months (does not include 12 month checkup)</td>
<td>6</td>
</tr>
<tr>
<td>1 through 4 years</td>
<td>7</td>
</tr>
<tr>
<td>5 through 11 years</td>
<td>7</td>
</tr>
<tr>
<td>12 through 17 years</td>
<td>6</td>
</tr>
<tr>
<td>18 through 20 years</td>
<td>3</td>
</tr>
</tbody>
</table>

All of the checkups listed on the periodicity schedule were developed according to the recommendations of the AAP and in consultation with recognized authorities in pediatric preventive health. In Texas, the THSteps periodicity schedule may differ from the AAP periodicity schedule based on the scheduling of laboratory or other tests in federal EPSDT or state regulations.

For more information about conducting a THSteps checkup, providers can refer to the THSteps online educational modules at www.txhealthsteps.com.
The following table includes the procedure codes for checkups and the referral and condition indicators. Condition indicators must be used to describe the results of a checkup. A condition indicator must be submitted on the claim with the periodic medical checkup visit procedure code. Indicators are required whether a referral was made or not. If a referral is made, then providers must use the Y referral indicator. If no referral is made, then providers must use the N referral indicator.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Referral Indicator</th>
<th>Condition Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381, 99382, 99383, 99384, and 99385 (new client preventive visit)</td>
<td>N (no referral given)</td>
<td>NU (not used)</td>
</tr>
<tr>
<td>-or-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99391, 99392, 99393, 99394, and 99395 (Established client preventive visit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99381, 99382, 99383, 99384, and 99385 (new client preventive visit)</td>
<td>Y (yes THSteps or EPSDT referral was given to the client)</td>
<td>S2 (under treatment) or ST* (new services requested)</td>
</tr>
<tr>
<td>-or-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99391, 99392, 99393, 99394, and 99395 (established client preventive visit)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* The ST condition indicator should only be used when a referral is made to another provider or the client must be rescheduled for another appointment with the same provider. It does not include treatment initiated at the time of the checkup.

A checkup must be submitted with diagnosis code V202. When performed for a THSteps preventive care medical checkup, procedure codes 99385 and 99395 are restricted to clients who are 18 through 20 years of age.

Modifier AM, SA, TD, or U7 must be submitted with the THSteps medical checkups procedure code to indicate the practitioner who performed the unclothed physical examination during the medical checkup.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Physician, team member service</td>
</tr>
<tr>
<td>SA</td>
<td>Nurse practitioner rendering service in collaboration with a physician</td>
</tr>
<tr>
<td>TD</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>U7</td>
<td>Physician assistant</td>
</tr>
</tbody>
</table>

THSteps medical checkups performed in an FQHC or RHC setting are paid an all-inclusive rate per encounter, which includes immunizations, developmental screening, autism screening, TST, blood lead test, and oral evaluation and fluoride varnish. When submitting claims for THSteps checkups and services, RHC providers must use the national POS code 72, and FQHC providers must use modifier EP in addition to the modifiers used to identify who performed the medical checkup. In accordance with the federal rules for RHCs and FQHCs, an RN in an RHC or FQHC may not perform THSteps checkups independently of a physician’s interactions with the client.

Refer to: Section 4, “Federally Qualified Health Center (FQHC)” in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for information related to billing

Section 7, “Rural Health Clinic” in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for information related to billing.

Checkups, exception-to-periodicity checkups, and follow-up visits are limited to once per day any provider.
A checkup and the associated follow-up visit may not be reimbursed on the same date of service. The follow-up visit will be denied.

An incomplete checkup is subject to recoupment unless there is documentation to support why the component was not completed as part of the checkup.

A new patient is one who has not received any professional services within the preceding three years from the provider or from another provider of the same specialty who belongs to the same group practice. As an exception, a new preventive care medical checkup (procedure code 99381, 99382, 99383, 99384, or 99385) may be billed when no prior checkups have been billed by the same provider or provider group, even if an acute care new patient E/M service was previously performed by the same provider.

An additional new checkup is allowed only when the client has not received any professional services in the preceding three years from the same provider or another provider who belongs to the same group practice, because subsequent acute care visits to the new patient THSteps checkup continues the established relationship with the provider.

If the provider that performs the medical checkup provides treatment for an identified condition on the same day, the provider may submit a separate claim for an acute care established-client office visit. The separate claim must include the established-client procedure code that is appropriate for the diagnosis and treatment of the identified problem. Treatment of minor illnesses or conditions (e.g., follow-up of a mild upper respiratory infection) during the THSteps medical checkup may not warrant additional billing.

**Acute Care Visits**

When a new patient checkup is billed for the same date of service as a new patient acute care visit, both new patient services may be reimbursed when billed by the same provider or provider group if no other acute care visits or preventive care medical checkups have been billed in the past three years.

Providers must use modifier 25 to describe circumstances in which an acute care E/M visit was provided at the same time as a checkup. Providers must submit modifier 25 with the E/M procedure code when the rendered services are distinct and provided for a different diagnosis. Providers must bill an appropriate level E/M procedure code with the diagnosis that supports the acute care visit. The medical record must contain documentation that supports the medical necessity and the level of service of the E/M procedure code that is submitted for reimbursement.

An acute care E/M visit for an insignificant or trivial problem or abnormality billed on the same date of service as a checkup or exception-to-periodicity checkup is subject to recoupment.

Providers must bill an acute care visit with their provider identifier on a separate claim without benefit code EP1.

**5.3.7 Exception-to-Periodicity Checkups**

Exception-to-periodicity checkups are complete medical checkups completed outside the timeframes listed in the THSteps Periodicity Schedule due to extenuating circumstances.

Exception-to-periodicity checkups are complete medical checkups, which are medically necessary and might cause the total number of checkups to exceed the number allowed for the client’s age range if the client were to have all regular scheduled checkups. An exception-to-periodicity checkup is allowed when:

- Medically necessary, for example, for a client with developmental delay, suspected abuse, or other medical concerns or a client in a high-risk environment, such as living with a sibling with elevated blood lead.
- Required to meet state or federal exam requirements for Head Start, day care, foster care, or preadoption.
• When needed before a dental procedure requiring general anesthesia.

As noted in the Periodic Checkup Age Range table, the number of checkups is set for each age range. This may avoid an exception-to-periodicity checkup and allow flexibility for the provider and family to schedule a checkup including before the child’s birthday.

If a client is due for a medical checkup, a checkup outside of the regular THSteps schedule must be billed as a regular checkup rather than an exception to periodicity.

The checkup is considered complete when all the required components are documented in the client’s medical record or supporting documentation, which details the reason a component(s) was not completed. A plan to complete the component(s) if not due to reasons of conscious or parental concerns must be included in the documentation.

**Note:** A sports physical is not a reason for an exception-to-periodicity checkup.

When billing for an exception-to-periodicity visit, provider must also include the most appropriate exception-to-periodicity modifiers. Claims for periodic THSteps medical checkups exceeding periodicity that do not include one for these modifiers will be denied as exceeding periodicity.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>Medically necessary service or supply</td>
</tr>
<tr>
<td>23</td>
<td>Unusual Anesthesia: Occasionally, a procedure that usually requires either no anesthesia or local anesthesia must be done under general anesthesia because of unusual circumstances. This circumstance may be reported by adding the modifier “23” to the procedure code of the basic service.</td>
</tr>
<tr>
<td>32</td>
<td>Mandated Services: Services related to mandated consultation or related services (e.g., PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding the modifier “32” to the basic procedure.</td>
</tr>
</tbody>
</table>

THSteps medical exception-to-periodicity services must be billed with the same procedure codes, provider type, modifier, and condition indicators as a medical checkup. Additionally, providers must use modifiers 23, 32, and SC to indicate the exception.

**5.3.8 Follow-up Medical Checkup**

Use procedure code 99211 with the provider identifier and THSteps benefit code when billing for a follow-up visit.

**Note:** Reimbursement may not be allowed for the follow-up visit when submitted with certain procedure codes.

A follow-up visit may be required to complete necessary procedures related to a THSteps medical checkup or exception-to-periodicity checkup, such as:

- Reading the TST.
- Administering immunizations in cases where the client’s immunizations were not up-to-date, medically contraindicated, or unable to be given on the initial visit.
- Collection of specimens for laboratory testing that were not obtained during the original THSteps medical checkup or the original specimen could not be processed.
- Completion of sensory or developmental screening that was not completed at the time of the THSteps medical checkup due to the client’s condition.

A return visit to follow up on treatment initiated during a checkup or to make a referral is not a follow-up visit, but is considered an acute care visit under an appropriate E/M procedure code for an established client.
If the parent or guardian did not give consent for a component during the initial checkup, and supporting documentation is provided, no follow-up visit is necessary.

5.3.9 Newborn Examination

Providers do not have to be enrolled as THSteps providers to bill newborn examination procedure codes 99460, 99461, or 99463.

Newborn examinations that are billed with procedure code 99460, 99461, or 99463 may qualify as a THSteps medical checkup when all required components are completed according to the THSteps Periodicity Schedule and documented in the medical record.

Providers must use their provider identifier without benefit code EP1 when billing newborn examination services.

Note: In Texas, the mandated newborn hearing screening and newborn screening test is included as part of the in-hospital newborn exam.

Providers billing these newborn codes are not required to be THSteps providers, but they must be enrolled as Medicaid providers. TMHP encourages THSteps enrollment for all providers that offer a medical home for clients and provide them with medical checkups and immunizations. Physicians and hospital staff are encouraged to inform parents eligible for Medicaid that the next THSteps checkup on the periodicity schedule should be scheduled from discharge to five days of age and that regular checkups should be scheduled during the first year and after.

Refer to: Subsection 9.2.45, “Newborn Services” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for additional information on inpatient newborn services.

The THSteps online education module “Newborn Hearing Screening” on the THSteps website at www.txhealthsteps.com for additional information about conducting a newborn hearing screen.

5.3.10 THSteps Medical Checkups Periodicity Schedule

The client is periodically eligible for medical checkup services based on the THSteps Medical Checkups Periodicity Schedule. All the checkups listed on the periodicity schedule have been developed based on recommendations of the AAP and recognized authorities in pediatric preventive health. In Texas, THSteps has modified the AAP periodicity schedule based on the scheduling of a laboratory or other test in federal EPSDT or state regulations.

The THSteps Medical Checkups Periodicity Schedule is available on the DSHS website at www.dshs.state.tx.us/thsteps/providers.shtm.

5.3.11 Mandated Components

THSteps medical checkups must include regularly scheduled examinations and screenings of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth.

The following federal and state mandated components must be documented in the client’s medical record for the checkup to be considered complete:

- Comprehensive health and developmental history, including physical and mental health development
- Comprehensive unclothed physical examination
- Immunizations appropriate for age and health history
- Laboratory test appropriate to age and risk, including lead toxicity at specific federally-mandated ages
- Health education including anticipatory guidance
• Dental referral

The client’s medical record must include documentation to support the rationale a component was not completed, and a plan to complete the component(s) if not due to parent or caregiver concern or reasons of conscience, including religious beliefs. THSteps provides optional clinical records to assist the provider in the documentation of the required components. These forms may be found at www.dshs.state.tx.us/thsteps/forms.shtm.

If the client has a condition that has been previously diagnosed and is currently receiving treatment, the associated standardized screening may be omitted with proper documentation.

Documented test or screening results obtained within the preceding 30 days for clients who are two years of age and younger, and the preceding 90 days for clients who are three years of age and older may be used to meet the testing or screening requirements. Results must include the dates of service and one of the following:

• A clear reference to the previous visit by the same provider

5.3.11.1 Comprehensive Health and Developmental History

5.3.11.1.1 Nutritional Screening

Dietary practices must be evaluated at each checkup to identify and address nutritional issues or concerns.

5.3.11.1.2 Developmental Surveillance or Screening

Developmental surveillance or screening is a required component of every checkup for clients who are birth through 6 years of age. Autism screening is required at 18 months of age. If not completed at 18 months of age, or if there is a particular concern it should be completed at 24 months of age.

As a THSteps medical service, developmental screening (procedure code 96110) or autism screening (procedure code 96110 with modifier U6) is limited to once per day, per client, by the same provider or provider group. This service will be denied unless a checkup, exception-to-periodicity checkup, or follow-up visit was reimbursed for the same date of service by the same provider.

Standardized developmental screening is required at the ages listed in the table below. Providers must use one of the validated, standardized tools listed below when performing a developmental or autism screening. A standardized screen is not required at other checkups up to and including the 6-year checkup; however, developmental surveillance is required at these visits and includes a review of milestones (gross and fine motor skills, communication skills, speech-language development, self-help/care skills, and social, emotional, and cognitive development) and mental health and is not considered a separate service.

Update: Providers may be reimbursed separately when using one of the required screening tools listed in the table below in addition to the checkup visit at specific age visits. THSteps requires one of the following required standardized tools at the following ages for a checkup to be considered complete:

<table>
<thead>
<tr>
<th>Screening Ages</th>
<th>Developmental Screening Tools</th>
<th>Autism Screening Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 months</td>
<td>Ages and Stages Questionnaire (ASQ) or Parents’ Evaluation of Development Status (PEDS)</td>
<td>N/A</td>
</tr>
<tr>
<td>18 months</td>
<td>ASQ or PEDS</td>
<td>Modified Checklist for Autism in Toddlers (M-CHAT)</td>
</tr>
<tr>
<td>24 months</td>
<td>ASQ or PEDS</td>
<td>N/A</td>
</tr>
</tbody>
</table>
If a developmental or autism screening that is required in the Required Screening Ages and Recommended Tools table is not completed during a checkup or if the client is being seen for the first time, standardized developmental screening must be completed through 6 years of age.

If a provider administers a standardized and validated developmental screening at additional checkups other than those listed in the Required Screening Ages and Recommended Tools table, the provider must document the rationale for the additional screening, which may be due to provider or parental concerns.

Developmental screening that is completed without the use of one of the required standardized screening tools is not a separately payable benefit, and the checkup will be considered incomplete.

Standardized developmental screening as part of a medical checkup and for ages other than required on the periodicity schedule is not covered when completed for the sole purpose of meeting day care, Head Start, or school program requirements.

Standardized developmental screening may be performed outside a THSteps medical checkup as part of development and neurological assessment testing.

Refer to: Subsection 9.2.25, “Developmental and Neurological Assessment and Testing” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2 Provider Handbooks) for information related to developmental screening testing outside a THSteps medical checkup.

Referral for an in-depth developmental evaluation is determined by the criteria of the specific tool or at the provider’s discretion. Referral for in-depth evaluation of development should be provided when parents express concern about their child’s development, regardless of scoring on a standardized development screening tool. A medical diagnosis or a confirmed developmental delay is not required for referrals.

The ECI program serves clients who are birth through 35 months of age with disabilities or developmental delays. Under federal and state regulations, all health-care professionals are required to refer children to the Texas ECI program as soon as possible, but no longer than 7 days after identifying a disability or a suspected delay in development, even if referred to an appropriate provider for further testing. If the client is 3 years of age or older, referral should be made to the local school district’s special education program.

5.3.11.1.3 Mental Health Screening

Mental health screening for behavioral, social, and emotional development is required at each THSteps checkup.

When the clinician conducting the mental health screen has the appropriate training and credentials to conduct the mental health evaluation and provide treatment, the clinician may choose to provide the mental health services or refer the client to an appropriate clinician. Clinicians who do not have these qualifications must refer clients to a qualified Medicaid-enrolled mental health specialist for such care.

For additional information about conducting a mental health screen, providers can refer to the THSteps online educational module “Mental Health Screening” at www.txhealthsteps.com.
5.3.11.1.4 Tuberculosis (TB) Screening
Administer the TB risk screening tool annually beginning at 12 months of age and thereafter at other medical checkups.

The TB risk screening tool is available on the DSHS website at www.dshs.state.tx.us/thsteps/forms.shtm.

A TST is to be administered when the screening tool indicates a risk for possible exposure. Providers must use procedure code 86580 when a TST is administered.

A TST may be reimbursed separately when performed as part of a THSteps medical checkup visit. TB screenings are part of the encounter rates for FQHCs and RHCs and are not reimbursed separately.

A follow-up visit (procedure code 99211) is required to read all TSTs. The provider may bill the follow-up visit with a provider identifier and THSteps benefit code.

If further evaluation is required to diagnose either latent TB infection or active TB disease, the provider may bill the appropriate E/M office visit code. Diagnosis and treatment are provided as a medical office visit. Providers can also call the TB program at (512) 533-3000 for additional clinical information.


5.3.11.2 Comprehensive Unclothed Physical Examination
An age-appropriate unclothed physical examination is required at each checkup.

Recording of measurements and percentiles as appropriate to age to document growth and development including:

- Length or height and weight
- Fronto-occipital circumference (FOC) through the first 24 months of age
- Body mass index (BMI) calculated beginning at 2 years of age
- Blood pressure beginning at 3 years of age

5.3.11.2.1 Oral Health Screening
Oral health screening is a part of the medical checkup physical examination.

5.3.11.2.2 Sensory Screening
Documentation of test results from a school vision or hearing screening program may replace the required audiometric or visual acuity screening if conducted within 12 months prior to the checkup.

Clients who are birth through 35 months of age with suspected or confirmed hearing or visual impairment must be referred to ECI as soon as possible, but no longer than 7 days after identification.

5.3.11.2.3 Hearing Screening
State-mandated newborn hearing screening is offered by and performed in the birth facility in accordance with Health and Safety Code (HSC), Chapter 47, §§ 47.001 – 47.009 and TAC, Title 25, Part 1, Chapter 37, Subchapter S, §§ 37.501 – 37.512.

The provider must review the results with the parent or caregiver at the first visit and determine if any additional follow-up is necessary.

Hearing screening must be performed at each visit. Audiometric screening must be performed at specific ages indicated on the periodicity schedule. Subjective screening through provider observation or informant report is done at the other checkups.
Clients at high risk or with abnormal screening results must be referred to an appropriate Medicaid-enrolled provider who specializes in pediatric audiology services. Clients who are birth through 20 years of age enrolled with Texas Medicaid for the date(s) of service are eligible for Texas Medicaid hearing services benefits.

5.3.11.2.4 Vision Screening

Vision screening must be performed at each visit. A visual acuity test must be performed at ages indicated on the periodicity schedule. Subjective screening through provider observation or informant report is done at the other checkups.

All clients must be screened for eye abnormalities by history, observation, and physical exam and referred to a Medicaid-enrolled optometrist or ophthalmologist experienced with the pediatric population if at high risk.

Clients with abnormal visual acuity screening results must be referred to a Medicaid-enrolled optometrist or ophthalmologist experienced with the pediatric population.

5.3.11.3 Immunizations

Providers must assess the immunization status at every medical checkup to ensure all age requirements have been met. The necessary vaccines and toxoids must be administered at the time of the checkup unless medically contraindicated or because of parent’s or caregiver’s reasons of conscience including religious beliefs. If an indicated vaccine or toxoid was not administered, the reason must be documented in the client’s medical record.

Vaccines and toxoids must be administered according to the current ACIP “Recommended Childhood and Adolescent Immunization Schedule - United States.” Providers must not refer clients to the local health department or other entity for immunization administration.

Vaccines and toxoids must be obtained from TVFC for clients who are birth through 18 years of age. Vaccines that are identified as being distributed through TVFC are not reimbursed separately.

The specific diagnosis necessitating the vaccine and toxoid is required when billing with the following administration procedure codes in combination with an appropriate vaccine/toxoid procedure code:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90460</td>
</tr>
</tbody>
</table>

Diagnosis code V202 may be used unless a more specific diagnosis code is appropriate.

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered.

Procedure codes 90471 and 90472 are benefits for services rendered to clients of any age when counseling is not provided for the immunization administered.

Procedure codes 90473 and 90474 are benefits for services rendered to clients who are birth through 20 years of age when counseling is not provided for the immunization administered.

The following vaccines and toxoids are a benefit of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Number of Components**</th>
<th>Procedure Code</th>
<th>Number of Components**</th>
<th>Procedure Code</th>
<th>Number of Components**</th>
</tr>
</thead>
<tbody>
<tr>
<td>90632</td>
<td>1</td>
<td>90633*</td>
<td>1</td>
<td>90636</td>
<td>2</td>
</tr>
<tr>
<td>90644</td>
<td>2</td>
<td>90647*</td>
<td>1</td>
<td>90648*</td>
<td>1</td>
</tr>
<tr>
<td>90649*</td>
<td>1</td>
<td>90650*</td>
<td>1</td>
<td>90654</td>
<td>1</td>
</tr>
</tbody>
</table>
Providers may use the state-defined modifier U1 in addition to the associated administered vaccine procedure code for clients who are birth through 18 years of age and the vaccine was unavailable through TVFC.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Number of Components**</th>
<th>Procedure Code</th>
<th>Number of Components**</th>
<th>Procedure Code</th>
<th>Number of Components**</th>
</tr>
</thead>
<tbody>
<tr>
<td>90655*</td>
<td>1</td>
<td>90656*</td>
<td>1</td>
<td>90657*</td>
<td>1</td>
</tr>
<tr>
<td>90658*</td>
<td>1</td>
<td>90660*</td>
<td>1</td>
<td>90669</td>
<td>1</td>
</tr>
<tr>
<td>90670*</td>
<td>1</td>
<td>90672*</td>
<td>1</td>
<td>90680*</td>
<td>1</td>
</tr>
<tr>
<td>90681*</td>
<td>1</td>
<td>90686*</td>
<td>1</td>
<td>90696*</td>
<td>4</td>
</tr>
<tr>
<td>90698*</td>
<td>5</td>
<td>90700*</td>
<td>3</td>
<td>90702*</td>
<td>2</td>
</tr>
<tr>
<td>90703</td>
<td>1</td>
<td>90707*</td>
<td>3</td>
<td>90710*</td>
<td>4</td>
</tr>
<tr>
<td>90713*</td>
<td>1</td>
<td>90714*</td>
<td>2</td>
<td>90715*</td>
<td>3</td>
</tr>
<tr>
<td>90716*</td>
<td>1</td>
<td>90721</td>
<td>4</td>
<td>90723*</td>
<td>5</td>
</tr>
<tr>
<td>90732*</td>
<td>1</td>
<td>90733</td>
<td>1</td>
<td>90734*</td>
<td>1</td>
</tr>
<tr>
<td>90743</td>
<td>1</td>
<td>90744*</td>
<td>1</td>
<td>90746</td>
<td>1</td>
</tr>
<tr>
<td>90749</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* TVFC-distributed vaccine/toxoid
** The number of components applies if counseling is provided and procedure code 90460 and 90461 are submitted.

Note: “Unavailable” is defined as a new vaccine approved by ACIP that has not been negotiated or added to a TVFC contract, funding for new vaccine that has not been established by TVFC, or national supply or distribution issues. Providers will be informed if a vaccine meets the definition of ‘not available’ from TVFC and when the provider’s privately purchased vaccine may be billed with modifier U1.

Modifier U1 may not be used for failure to enroll in TVFC, maintain sufficient TVFC vaccine/toxoid inventory, or clients who are 19 through 20 years of age.

Each vaccine or toxoid and its administration must be submitted on the claim in the following sequence: the vaccine procedure code immediately followed by the applicable immunization administration procedure code(s). All of the immunization administration procedure codes that correspond to a single vaccine or toxoid procedure code must be submitted on the same claim as the vaccine or toxoid procedure code.

Each vaccine or toxoid procedure code must be submitted with the appropriate “administration with counseling” procedure code(s) (procedure codes 90460 and 90461) or the most appropriate “administration without counseling” procedure code (procedure code 90471, 90472, 90473, or 90474). If an “administration with counseling” procedure code is submitted with an “administration without counseling” procedure code for the same vaccine or toxoid, the administration of the vaccine or toxoid will be denied.

Administration With Counseling
Providers must submit claims for immunization administration procedure codes 90460 or 90461 based on the number of components per vaccine. Providers must specify the number of components per vaccine by billing 90460 and 90461 as defined by the procedure code descriptions:
• Procedure code 90460 is submitted for the administration of the 1st component.

• Procedure code 90461 is submitted for the administration of each additional component identified in the vaccine.

Procedure code 90461 will be denied if procedure code 90460 has not been submitted on the same claim for the same vaccine or toxoid.

The necessary counseling that is conducted by a physician or other qualified health-care professional must be documented in the client’s medical record.

The following is an example of how to submit claims for immunization administration procedure codes when counseling is provided:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine or toxoid procedure code with 1 component</td>
<td>1</td>
</tr>
<tr>
<td>90460 (1st component)</td>
<td>1</td>
</tr>
<tr>
<td>Vaccine or toxoid procedure code with 3 components</td>
<td>1</td>
</tr>
<tr>
<td>90460 (1st component)</td>
<td>1</td>
</tr>
<tr>
<td>90461 (2nd and 3rd components)</td>
<td>2</td>
</tr>
</tbody>
</table>

**Note:** The term “components” refers to the number of antigens that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.

**Administration Without Counseling**

Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed per vaccine based on the route of administration.

The following is an example of how to submit claims for injection administration procedure codes when counseling is not provided:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine or toxoid procedure code</td>
<td>1</td>
</tr>
<tr>
<td>90471 (Injection administration)</td>
<td>1</td>
</tr>
<tr>
<td>Vaccine or toxoid procedure code</td>
<td>1</td>
</tr>
<tr>
<td>90472 (Injection administration)</td>
<td>1</td>
</tr>
<tr>
<td>Vaccine or toxoid procedure code</td>
<td>1</td>
</tr>
<tr>
<td>90472 (Injection administration)</td>
<td>1</td>
</tr>
</tbody>
</table>

**5.3.11.3.1 Vaccine Information Statement (VIS)**

A VIS is required by federal mandate to inform parents and vaccine recipients of the risks and benefits of the vaccine they are about to receive. Not only is it important to explain the risks and benefits before a vaccine is administered, it is also important that providers use the most current forms available. For more about immunizations, vaccine-preventable diseases, or literature and forms, providers can call the DSHS Immunization Branch at 1-800-252-9152 or review information at www.dshs.state.tx.us/immunize.

**Refer to:** Appendix B: Immunizations in this handbook.

Form CH.40, “TVFC Provider Enrollment (3 Pages)” in Appendix A, “THSteps Forms,” in this handbook for more information on enrolling as a TVFC provider.

The THSteps online education module “Immunizations,” located on the THSteps website at www.txhealthsteps.com, for more information about immunizations.
5.3.11.4 Health Education and Anticipatory Guidance

Anticipatory guidance is a federally mandated component of the THSteps medical checkup and includes health education and counseling. Health education and counseling with parents or guardians and clients are required to assist parents in understanding what to expect in terms of the client’s development and to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. Written material may also be given but does not replace counseling. The optional THSteps clinical records include age-appropriate topics on the back of each form. These forms can be found at www.dshs.state.tx.us/thsteps/forms.shtm.

5.3.11.5 Dental Referral

Based on the AAPD definition of a dental home, Texas Medicaid defines a dental home as the dental provider who supports an ongoing relationship with the client that is inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. In Texas, establishment of a client’s dental home should begin at 6 months of age but no later than 12 months of age and includes referral to dental specialists when appropriate.

The physician must refer clients to establish a dental home beginning at 6 months of age or earlier if trauma or early childhood caries are identified. For established clients after the six-month medical checkup visit, the provider must confirm if a dental home has been established and is on-going; if not, additional referrals must be made at subsequent medical checkup visits until the parent or caregiver confirms that a dental home has been established for the client. The parent or caregiver of the client may self-refer for dental care at any age, including 12 months of age or younger.

5.3.11.6 Laboratory Test

Aged-appropriate and risk-based laboratory testing as noted on the periodicity schedule is considered part of the medical checkup. The DSHS Laboratory provides supplies for specimen collection and mailing and shipping; and reporting of test results to enrolled THSteps medical providers that submit specimens to the DSHS Laboratory. These services and supplies are limited to THSteps medical checkup laboratory services provided in the course of a medical checkup to THSteps clients. Unauthorized use of services and supplies is a violation of federal regulations.

DSHS laboratory services are available at no cost to all enrolled THSteps medical providers for THSteps medical checkups only. THSteps laboratory services provided by a private laboratory and a medical provider are not reimbursed.

Example: If a provider needs immediate results for the anemia screening, the specimen may be processed in the office/clinic, and the test results must be documented in the client’s medical record but the provider will not be reimbursed.

Exception: For tests related to screening for type 2 diabetes, hyperlipidemia, HIV, and syphilis, the client or specimen may be sent to the laboratory of the provider’s choice. Point-of-care testing that is performed in the provider’s office to obtain the initial blood lead specimen may be reimbursed separately.

The date of service for the laboratory testing is to be the date the specimen was obtained as part of the medical checkup, follow-up visit, or exception-to-periodicity visit.

The procedure codes for any laboratory testing services other than screening for type 2 diabetes, hyperlipidemia, HIV, and syphilis are informational when obtained on the same day a checkup is completed, even if an acute care visit is performed on the same date of service.

If the laboratory testing as identified on the THSteps Medical Checkup Periodicity Schedule is obtained as part of an E/M visit on a different date of service than a checkup, the services may be considered as separate services and may be sent to the laboratory of the provider’s choice.
Laboratory specimens obtained for diagnostic evaluation, rather than for screening purposes and performed on the same day as a checkup, may be considered as separate services unless the test is required as part of a checkup. If the test is required as part of the checkup, the laboratory specimens, with the exception of screening tests for hyperlipidemia, type 2 diabetes, HIV, and syphilis must be submitted to the DSHS Laboratory for testing. Diagnostic specimens that are not part of the checkup can be sent to the laboratory of the provider’s choice.

Laboratory services that are related to a THSteps medical checkup are available from the DSHS Laboratory and may not be billed separately with an office visit or consultation on the same day as a THSteps medical checkup.

All of the laboratory tests that are listed on the THSteps Periodicity Schedule may be submitted to the DSHS Laboratory if the specimen submission requirements can be met. Tests that are listed in the “Laboratory Test Procedure Codes” table below must be submitted to the DSHS Laboratory. Tests that must be sent to a DSHS laboratory but that are processed elsewhere are not reimbursed; however, the documentation results may be used to meet the requirements for a checkup.

The following procedure codes may not be billed separately with an office visit or consultation on the same day as a THSteps medical checkup either by a provider or laboratory. Claims for procedure codes listed below submitted by a provider or a commercial laboratory for the same DOS as a THSteps medical checkup are denied and are subject to retrospective review:

<table>
<thead>
<tr>
<th>Laboratory Test Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>83665*</td>
</tr>
<tr>
<td>85018</td>
</tr>
<tr>
<td>87491</td>
</tr>
<tr>
<td>87591</td>
</tr>
</tbody>
</table>

* Unless performed using point-of-care testing, the initial lead specimen must be sent to the DSHS Laboratory

For specimens sent to the DSHS Laboratory, the complete medical checkup includes the specimen collection and supplies, mailing and shipping supplies, and the review of the test results from the DSHS Laboratory.

For specimens sent to a laboratory of the provider’s choice, the checkup includes the specimen collection or ordering of the test and the review of the test results from the laboratory.

5.3.11.6.1 Laboratory Supplies

The DSHS Laboratory verifies enrollment of THSteps medical providers before sending laboratory supplies and the informational packet to the medical providers. Newly enrolled providers should contact the DSHS Laboratory to request laboratory supplies. Upon request, the DSHS Laboratory provides THSteps medical providers with laboratory supplies associated with specimen collection, submission, and mailing and shipping of required laboratory tests related to medical checkups. Requests for specimen submission forms are routed to the DSHS Laboratory reporting staff and mailed separately to the providers. The Child Health Laboratory Supplies Order Form lists the laboratory supplies that the DSHS Laboratory provides to THSteps medical providers.

To obtain a THSteps Child Health Laboratory Supplies Order Form, providers can call (512) 776-7661 or 1-888-963-7111, ext. 7661, or download the form online at www.dshs.state.tx.us/lab/MRS_forms.shtm.

5.3.11.6.2 Newborn Screening Supplies

Providers that perform newborn screening (NBS) can order supplies by submitting a Newborn Screening Supplies Order Form to the DSHS Laboratory. The Newborn Screening Supplies Order Form lists the NBS supplies that the DSHS Laboratory provides to medical providers.

**Note:** For newborn screening, only the specimen collection form (NBS 3), mailing envelope and provider address labels are provided. Lancets, mailing, and shipping costs are the responsibility of the submitter.
To obtain a Newborn Screening Supplies Order Form, medical providers can call (512) 776-7661 or 1-888-963-7111, ext. 7661, or download the form online at www.dshs.state.tx.us/lab/MRS_forms.shtm.

Contact information for requesting laboratory supplies:

Container Preparation  
Laboratory Services Section, MC 1947  
Department of State Health Services  
PO Box 149347  
Austin, TX 78714-93471  
(512) 776-7661 or 1-888-963-7111, Ext. 7661  
Fax: (512) 776-7672

5.3.11.6.3 Laboratory Submission

All required laboratory testing for THSteps clients must be performed by the Department of State Health Services (DSHS) Laboratory in Austin, TX, with the following exceptions:

- Specimens collected for type 2 diabetes, hyperlipidemia, HIV, and syphilis screening may be sent to the laboratory of a provider’s choice or to the DSHS Laboratory in Austin if submission requirements can be met.

- Blood lead testing by point-of-care screening.

THSteps medical checkup laboratory specimens submitted to the DSHS Laboratory must be accompanied with the DSHS Laboratory Specimen Submission Form (Newborn Screening NBS 3 or G-THSTEPS as appropriate) for test(s) requested. All forms must include the client’s name and Medicaid number as they appear on the Your Texas Benefits card. If a number is not currently available but is pending (i.e., a newborn or a newly certified client verified by a Medicaid Eligibility Verification [Form H1027] as eligible for Medicaid), providers must write “pending” in the Medicaid number space, which is located in the payor source section of the laboratory specimen submission form.

Laboratory specimens received at the DSHS Laboratory without a Medicaid number or the word “pending” written on the accompanying specimen submission form will be analyzed, and the provider will be billed.

Specimens submitted to the laboratory must also meet specific acceptance criteria. For additional information on specimen submission, providers can refer to the DSHS Laboratory web page at: www.dshs.state.tx.us/lab/MRS-specimens.shtm.

**Note:** If an extreme health problem exists and telephone results are needed quickly, providers should make a request on the laboratory form. With the exception of weekends and holidays, routine specimens are analyzed and reported within three business days after receipt by the DSHS Laboratory. Critical abnormal test results (e.g., hemoglobin equal to or below 7g/dL or blood lead levels greater than or equal to 40 mcg/dL) are identified in the laboratory within 36 hours after receipt of specimens and are reported to the submitter by telephone within one hour of confirmation.

The THSteps laboratory specimens that can be mailed at ambient temperature can be sent to the DSHS Laboratory Services Section through the U.S. Postal Service at no cost using the provided business reply labels:

DSHS Laboratory Services Section  
Walter Douglass  
PO Box 149163  
Austin, TX 78714-9803  
(512) 776-7318 or 1-888-963-7111 Ext. 7318
THSteps laboratory specimens that require overnight shipping on cold packs through a courier service must be sent to the DSHS Laboratory Services Section at:

DSHS Laboratory Services Section, MC-1947  
1100 West 49th Street  
Austin, TX 78756-3199

Newborn Screening specimens can be sent through the U.S. Postal Service to:

Texas Department of State Health Services  
Laboratory Services Section  
PO Box 149341  
Austin, TX 78714-9341

Gonorrhea and Chlamydia specimens for regular delivery are sent to:

Department of State Health Services  
Laboratory - MC 1947  
Walter Douglass, (512) 776-7569  
PO Box 149163  
Austin, TX 78714-9803

Gonorrhea and Chlamydia specimens that are shipped cold overnight via courier are sent to:

Department of State Health Services  
Laboratory - MC 1947  
Walter Douglass, (512) 776-7569  
1100 W. 49th Street  
Austin, TX 78756-3199

Collectors are available from the DSHS Austin Laboratory. To order collectors, providers must complete the Order Form for Gonorrhea/Chlamydia (GC/CT) Laboratory Supplies (G-6C) that is posted on the DSHS website at www.dshs.state.tx.us/lab/mrs_forms.shtm and fax the completed form to (512) 776-7672.

Providers can call (512) 776-6030 or toll-free 1-888-963-7111, ext. 6030, for questions about submission requirements such as collection, supplies, and mailing of specimens for THSteps gonorrhea and chlamydia adolescent screening.

5.3.11.6.4 Send Comments

Providers with comments or feedback about THSteps specimen collection supplies should contact the DSHS Laboratory. Supplies are evaluated continually, and feedback from supply users is useful. Documented comments may support, justify, or initiate a change in a provided item. Providers can send a brief letter or fax to the following address:

Quality Assurance Unit  
Laboratory Services Section, MC 1947  
Department of State Health Services  
PO Box 149347  
Austin, TX 78714-9347  
Fax: (512) 776-7294

5.3.11.6.5 Laboratory Reporting

A computer-generated result report is mailed or faxed to the submitting THSteps medical checkup provider. A statistical report is mailed quarterly to providers documenting their total number of submissions by diagnosis and adequacy. The DSHS Laboratory has web-based services (remote order and result reporting) available for THSteps and Newborn Screening laboratory services. For more information, providers can visit the DSHS website at www.dshs.state.tx.us/lab/remoteData.shtm or call 1-888-963-7111, Ext. 6030.
5.3.11.6.6 Required Laboratory Tests Related to Medical Checkups

The following laboratory screening procedures are required components of the THSteps medical checkup and are to be performed in accordance with the age and frequency specified on the THSteps medical checkup periodicity schedule. Due to changes in specimen collection, handling, and submission criteria, providers should contact the DSHS Laboratory for the most current specimen requirements by calling 1-888-963-7111, Ext. 7430, email ClinicalChemistry@dshs.state.tx.us, or visiting the DSHS website at www.dshs.state.tx.us/lab/MRS_labtests_toc.shtm.

Anemia Screening

Anemia screening by hemoglobin or hematocrit levels is required at ages as noted on the THSteps Periodicity Schedule and the specimen must be sent to the DSHS laboratory. If there is an urgent need for test results, these tests may be completed in a provider’s office or clinic, but they will not be reimbursed separately. These test results must be documented in the client’s medical record.

Lead Screening and Testing

In accordance with current federal regulations, THSteps requires blood lead screening at ages notated on the THSteps Periodicity Schedule and must be performed during the medical checkup.

Environmental lead risk may be addressed at other visits using the Lead Risk Questionnaire, Form Pb-110, which is provided in both English and Spanish at www.dshs.state.tx.us/thsteps/forms.shtm. Providers may use an equivalent form of their choice.

The initial lead testing may be performed using a venous or capillary specimen, and must either be sent to the DSHS Laboratory or performed in the provider’s office using point-of-care testing. If the client has an elevated blood lead level of 10mcg/dL or greater, the provider must perform a confirmatory test using a venous specimen. The confirmatory specimen may be sent to the DSHS Laboratory, or the client or specimen may be sent to a laboratory of the provider’s choice.

All blood lead levels in clients who are 14 years of age or younger must be reported to DSHS. Reports should include all information as required on the Child Blood Lead Reporting, Form F09-11709 or the Point-of-Care Blood Lead Testing report Form Pb-111, which can be found at www.dshs.state.tx.us/lead/providers.shtm or by calling 1-800-588-1248.

Elevated blood lead levels for clients who are 15 years of age or older must be reported to DSHS and should include all information required on the Adult Blood Lead Report Form F09-11624.

Point-of-care lead testing (procedure code 83655 with modifier QW) may be reimbursed to THSteps medical providers when performed in the provider’s office. Providers must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver.

Blood lead testing is part of the encounter rates for FQHCs and RHCs and is not reimbursed separately.

Providers may obtain more information about the medical and environmental management of lead-poisoned children from the DSHS Childhood Lead Poisoning Prevention Program by calling 1-800-588-1248 or visiting the web page at www.dshs.state.tx.us/lead.

Refer to: Appendix C: Lead Screening in this handbook for more information on lead screening procedures and follow-up.

Hyperlipidemia

Screening for hyperlipidemia is based on risk assessment. THSteps does not provide a formal risk assessment tool. Providers may refer to the AAP policy statement on cholesterol screening for more information. Specimens may be sent to the laboratory of the provider’s choice, including the DSHS Laboratory.
Diabetes
Screening for type 2 diabetes is based on risk assessment. THSteps does not provide a formal risk assessment tool. Specimens may be sent to the laboratory of the provider’s choice, including the DSHS Laboratory.

Newborn Screening
Each newborn delivered in Texas must be subjected to two screens to test for a number of genetic and heritable disorders. Each newborn screen is indicated on the THSteps Periodicity Schedule. A current list of screened disorders is available at www.dshs.state.tx.us/newborn/screened_disorders.shtm.

Additional information about newborn screening, is available on the Newborn Screening Program website at www.dshs.state.tx.us/newborn/default.shtm.

The initial newborn screen specimen must be obtained between 24 and 48 hours after birth. Newborns discharged from a hospital or birthing facility before this time criteria is met must have a newborn screen blood specimen obtained immediately prior to discharge. When the newborn is an inpatient in the hospital, the hospital shall ensure that the appropriate screens are done. When the newborn is not in the hospital, the physician or health-care practitioner who attends the newborn outside of the hospital shall be responsible for causing the appropriate screens to be done. TAC Title 25, Part 1, Chapter 37, Subchapter D, Rule §37.55.

A second screen is to be obtained between one and two weeks of age by the newborn’s physician or health-care practitioner, and is a required component of the THSteps medical checkup. Clients may not be referred to the local health department or other providers for this service. If there is any doubt that a client younger than 12 months of age was properly tested, the provider should submit a screen on DSHS Form NBS 3 to the Texas Department of State Health Services, Laboratory Services Section, Austin, Texas.

Newborn screening tests may be performed in special circumstances, such as adoption, if there is not record of previous test results. Newborn screen results are mailed or faxed to the address that the provider indicated on DSHS Form NBS 3. Providers may sign up to receive results online through the DSHS Laboratory web-based services. For more information visit the DSHS website at www.dshs.state.tx.us/lab/remote.data.shtm or call 1-888-963-7111, Ext. 6030.

Note: Recommendations for necessary follow-up procedures are included with the newborn screen results. Newborn Screening (NBS) Clinical Care Coordination staff will contact providers when there are significant out of range newborn screening laboratory results.

5.3.11.6.7 Additional Required Laboratory Tests Related to Medical Checkups for Adolescents

The following is a list of required and risk-based laboratory tests related to medical checkups for adolescents and guidelines for testing for sexually transmitted diseases (STDs).

Testing for Sexually Transmitted Diseases
Syphilis Testing
Syphilis testing should be performed on adolescents that are at high risk for infection. Specimens may be sent to the laboratory of the provider’s choice, including the DSHS Laboratory.

Gonorrhea and Chlamydia Infection Testing
Testing for gonorrhea and Chlamydia should be performed on adolescents that are at high risk for infection. Specimens must be sent to the DSHS Laboratory in Austin.

HIV Testing
Clients should be informed that the HIV test is routinely available, confidential, and completely anonymous. It is critical to maintain confidentiality when caring for clients, as well as their specimens. Testing should be performed only after informed consent is obtained from the adolescent. Informed
consent does not have to be written as long as there is documentation in the medical record that the test has been explained and consent has been obtained. Specimens may be sent to the laboratory of the provider’s choice, including the DSHS Laboratory.

The CDC guidelines state that routine HIV screening should occur for everyone between 13 and 64 years of age. HIV testing is not required at these ages, but the offer should be made beginning at 13 years of age and if not performed at that time, should be offered at subsequent ages according to risk.

HIV testing may be performed for adolescents without requirement of parental consent. Adolescents at risk for HIV infection should be offered confidential HIV screening. If the client refuses the HIV test, the provider may not perform the test and must explain the option of anonymous testing and refer the client to a testing facility that offers anonymous testing. A notation must be made in the medical record that notification of the HIV test and the right to refuse was given. Providers may call the HIV/STD InfoLine for referrals to HIV/AIDS testing sites; prevention, case management, and treatment providers; STD clinics; and other related service organizations. The HIV/STD InfoLine is 1-800-299-2437. This toll-free HIV/AIDS and STD information and referral service is available for English- and Spanish-speaking callers and for those who are hearing-impaired.

**Communicable Disease Reporting**

Diagnoses of STDs, including HIV, are reportable conditions under 25 TAC, Chapter 97. Providers must report confirmed diagnoses of STDs as required by 25 TAC §97.132.

5.3.12 Non-mandated Components

5.3.12.1 Oral Evaluation and Fluoride Varnish (OEFV) in the Medical Home

An OEFV (procedure code 99429) is aimed at improving oral health outcomes for clients who are 6 through 35 months of age by initiating a limited set of preventive dental services (not a dental checkup) in the medical home.

The OEFV must be billed on the same date of service as a medical checkup visit and is limited to six services per lifetime by any provider. Procedure code 99429 must be billed with modifier U5 and diagnosis code V202 for an intermediate oral evaluation with fluoride varnish application.

An OEFV is not a required component of a THSteps medical checkup, but providers are encouraged to participate in this preventive intervention. OEFV is limited to THSteps medical checkup providers who have completed the required benefit education and are certified by the DSHS Oral Health Program to perform OEFV services.

Training for certification is available as a free continuing education course on the THSteps website at www.txhealthsteps.com.

The OEFV add-on includes the following components:

- Intermediate oral evaluation
- Inspection of teeth for signs of early childhood caries, and other caries
- Inspection of the oral soft tissues for any abnormalities
- Inspection for bleeding, swelling, or infection
- Indications of lack of cleaning of the mouth

The intermediate oral evaluation components that may be performed by a trained staff member are:

- Fluoride varnish application
- Dental anticipatory guidance to include:
  - The need for thorough daily oral hygiene practices
• Education in potential gingival manifestations for clients with diabetes and clients under long-term medication therapy
• THSteps eligibility qualifies the client for dental services
• Diet, nutrition, and food choices
• Fluoride needs
• Injury prevention
• Antimicrobials, medications, and oral health

If the client has no erupted teeth, additional dental anticipatory guidance is expected.

Note: The physician must complete the intermediate oral evaluation but can delegate all other components.

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

The following federal and state mandated components must be documented in the client’s medical record for the checkup to be considered complete:

• Comprehensive health and developmental history, including physical and mental health development
• Comprehensive unclothed physical examination
• Immunizations appropriate for age and health history
• Laboratory test appropriate to age and risk, including lead toxicity at specific federally mandated ages
• Health education including anticipatory guidance
• Dental referral

The client’s medical record must include documentation to support the rationale a component was not completed, and a plan to complete the component(s) if not due to parent or caregiver concern or reasons of conscience, including religious beliefs.

5.4.1 Separate Identifiable Acute Care Evaluation and Management Visit
If an acute or chronic condition that requires E/M beyond the required components for a medical checkup is discovered, a separate E/M procedure code may be considered for reimbursement for the same date of service as a checkup or the client can be referred for further diagnosis and treatment.

• The client’s medical record must contain documentation that the separate identifiable service(s) were medically necessary and include a diagnosis other than V202 (routine infant or child health check) and treatment. Documentation must be made available to Texas Medicaid upon request.

• An insignificant or trivial problem or abnormality that is encountered in the process of performing a checkup and does not require additional work and performance of the key components of a problem-oriented E/M service cannot be considered a separate established patient E/M acute care visit.

• Modifier 25 may be used to identify a significant, separately identifiable E/M service rendered by the same provider on the same day of the procedure or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.
5.5 Claims Filing and Reimbursement

Providers may refer to Volume 1 for general information about claims filing and reimbursement.

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

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


Section 6: Claims Filing (Vol. 1, General Information) for paper claims completion instructions.

Section 2: Texas Medicaid Fee-for-Service Reimbursement (Vol. 1, General Information) for more information about reimbursement.

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

5.5.1 Claims Information

THSteps Medical providers are not required to bill other insurance before billing Medicaid. If a provider is aware of other insurance, the provider must choose whether or not to bill the other insurance. The provider has the following options:

- If the provider chooses to bill the other insurance, the provider must submit the claim to the client’s other insurance before submitting the claim to Medicaid.
- If the provider chooses to bill Medicaid and not the client’s other insurance, the provider is indicating that he or she accepts the Medicaid payment as payment in full. Medicaid then has the right to recovery from the other insurance. The provider does not have the right to recovery and cannot seek reimbursement from the other insurance after Medicaid has made payment.
- If the provider learns that a client has other insurance coverage after Medicaid has paid a claim, the provider must refund the payment to Medicaid before billing the other insurance.

Providers should bill their usual and customary fee except for vaccines obtained from TVFC. Providers may not charge Medicaid or clients for the vaccine received from TVFC. Providers may charge a usual and customary fee not to exceed $22.06 for vaccine administration when providing immunizations to a client eligible for TVFC. Providers are reimbursed the lesser of the billed amount or the maximum allowable fee.

THSteps medical checkups may be billed electronically or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. Providers may request information about electronic billing or the paper claim form by contacting the TMHP THSteps Contact Center at 1-800-757-5691.

All procedures, including the informational-only procedures, must have a billed amount associated with each procedure listed on the claim. Informational-only procedure codes must be billed in the amount of at least $.01.

Providers must record the following on the CMS-1500 claim form to receive reimbursement for a medical checkup, exception to periodicity checkup, or follow-up visit:

- The provider identifier and benefit code EP1 (exception: FQHC providers do not use benefit code EP1)
- The appropriate THSteps medical checkup procedure code (all ages) with diagnosis code V202
The condition indicator codes, which must be placed in 24C (ST, S2, or NU only to identify a checkup resulting in a referral)

- The provider type modifiers
- The exception-to-periodicity modifier, when applicable

Refer to: Subsection 5.3.6, “THSteps Medical Checkups” in this handbook for a listing of modifiers.

- The immunization administration and vaccine procedure codes if any were administered (all ages)
- The place of service must be 72 for RHCs
- The EP modifier must be used for FQHCs

Immunizations performed outside of a THSteps medical checkup must be billed without the benefit code EP1.

5.5.2 Reimbursement

As with all Medicaid services, providers acknowledge compliance with all Texas Medicaid requirements when they submit a claim for reimbursement. THSteps-enrolled providers are reimbursed for THSteps medical checkups and administration of immunizations in accordance with 1 TAC §355.8441.

Note: NP, CNS, and PA providers who are enrolled in Texas Medicaid as THSteps providers may receive the full reimbursement for THSteps services.

FQHCs are reimbursed using visit rates calculated in accordance with 1 TAC §355.8261.

RHCs are reimbursed using visit rates calculated in accordance with 1 TAC §355.8101.

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

6. CLAIMS RESOURCES

Refer to the following sections or 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>vii (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Claim Form Example</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Comprehensive Outpatient Rehabilitation Facility (CORF) (CCP Only) Claim Form Example</td>
<td>Form CH.20, Section 9 of this handbook</td>
</tr>
<tr>
<td>THSteps Dental Criteria for Dental Therapy Under General Anesthesia (2 Pages)</td>
<td>Form CH.14, Section 8 of this handbook</td>
</tr>
<tr>
<td>Donor Human Milk Request Form</td>
<td>Form CH.6, Section 8 of this handbook</td>
</tr>
<tr>
<td>Durable Medical Equipment (CCP Only) Claim Form Example</td>
<td>Form CH.22, Section 9 of this handbook</td>
</tr>
<tr>
<td>Early Childhood Intervention Specialized Skills Training (SST) Claim Form Example</td>
<td>Form CH.23, Section 9 of this handbook</td>
</tr>
<tr>
<td>Medical Nutrition Counseling (CCP Only) Claim Form Example</td>
<td>Form CH.27, Section 9 of this handbook</td>
</tr>
<tr>
<td>Occupational Therapists (CCP Only) Claim Form Example</td>
<td>Form CH.28, Section 9 of this handbook</td>
</tr>
<tr>
<td>Orthotic and Prosthetic Services (CCP Only) Claim Form Example</td>
<td>Form CH.29, Section 9 of this handbook</td>
</tr>
</tbody>
</table>
7. CONTACT TMHP

For a complete list of TMHP communications, refer to the TMHP Telephone and Address Guide (Vol. 1, General Information).

7.1 Automated Inquiry System (AIS)

AIS (1-800-925-9126, Option 1) is available 7 days a week, 23 hours a day, with scheduled downtime between 3 a.m. and 4 a.m., and is the main point of contact for client eligibility information. AIS requires the use of a touch-tone telephone in order to access the system.
7.2 TMHP Website
Additional information about Medicaid enrollment, general customer service, and provider education/training is available on the TMHP website at www.tmhp.com.

7.3 Dental Information and Assistance
For assistance with claims, dental providers may contact a TMHP Contact Center representative on the Dental Inquiry Line (1-800-568-2460).

7.3.1 Dental Inquiry Line
The Dental Inquiry Line (1-800-568-2460) is available Monday through Friday, 7 a.m. to 7 p.m., Central Time, and is the main point of contact for information about dental services and appeals.

Any dental service claim denial may be appealed by telephone if it was not denied as an incomplete claim and does not require one of the following items or conditions:

- Narratives
- Radiographs
- Models
- Other tangible documentation
- Review by the TMHP Dental Director

7.4 THSteps Information and Assistance
Providers with questions, concerns, or problems about claims should contact the TMHP Contact Center (1-800-925-9126). For contact information for their regional TMHP Provider Representative, providers can refer to the TMHP website at www.tmhp.com. Click on the Regional Support link.

7.4.1 THSteps Inquiry Line
The THSteps Medical Inquiry Line at 1-800-757-5691 is available Monday through Friday, 7 a.m. to 7 p.m., Central Time, and is the main point of contact for information about THSteps medical services.

7.5 Assistance with Program
Providers with questions, concerns, or problems with program rules, policies, or procedures should contact DSHS regional program staff. THSteps staff contact numbers can be found in Appendix A: State and Federal Offices Communication Guide, (Vol. 1, General Information), on the THSteps website at www.dshs.state.tx.us/thsteps/default.shtm, or by calling THSteps at (512) 776-7745.

THSteps regional staff make routine contact with providers to educate and assist them with THSteps policies and procedures.

Clients who are eligible for Medicaid and have questions about THSteps, need to locate medical or dental providers, or need assistance with arranging transportation to appointments should call the THSteps toll-free helpline (1-877-847-8377). Clients with questions about their Medicaid eligibility for THSteps should be directed to their caseworker at the local HHSC office or site.

8. FORMS
# CCP Prior Authorization Request Form Instructions (2 pages)

## CCP Prior Authorization Request Form Instructions

### General Instructions

This form must be completed and signed as outlined in the instructions below before providers contact TMHP Comprehensive Care Program (CCP) for prior authorization.

Either the requesting Medicaid provider or the prescribing physician may initiate the form. The completed form with the original dated signature must be retained by the prescribing physician in the client’s medical record. A copy of the signed and dated form must be maintained by the requesting provider in the client’s medical record. The form is subject to retrospective review.

The Medicaid provider or prescribing physician may complete the following sections:

- Request for Services check boxes
- Section A: Client Information
- Section B: Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information
- Section D: Dates of Service and Healthcare Common Procedure Coding System (HCPCS) Procedure Codes

The prescribing physician must complete the following sections:

- Section C: Diagnosis and Medical Necessity of Requested Services
- Section E: Primary Practitioner’s Certifications

All fields must be filled out completely.

### Request for Services

Check the appropriate type of service being requested. Only one box may be selected.

<table>
<thead>
<tr>
<th>Request for:</th>
<th>DME</th>
<th>Supplies</th>
<th>Private Duty Nursing</th>
<th>Inpatient Rehabilitation</th>
<th>Other</th>
</tr>
</thead>
</table>

### Section A: Client Information

Enter the client's name, Medicaid number, and date of birth as indicated on the Texas Medicaid eligibility card or form.

Client Name (Last, First, MI): Jane Doe

Medicaid Number (PCN): 987654321  Date of Birth: 01 / 01 / 01

### Section B: Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information

Enter the name, telephone, fax number, address, TPI, and NPI of the Medicaid Provider who will be providing the requested service or benefit. If requesting a wheeled mobility system, enter the QRP’s name, TPI, and NPI.

Supplier Name: ABC DME Company  Telephone: 123-555-1234  Fax Number: 123-555-2345

Supplier Address: 123 Street, Somewhere, TX 12345-1234

TPI: 1234567-01  NPI: 123456789  Taxonomy: 123XX4567X  Benefit Code: XXX

QRP Name: B. Provider  QRP TPI: 987321654-01  QRPI NPI: 121212121

### Section C: Diagnosis and Medical Necessity of Requested Services

The prescribing physician must include an ICD-9 diagnosis code with a brief description and complete justification for determination of medical necessity for the requested items or services. If applicable, the prescribing physician should include the client’s height/weight, wound/stage/dimensions, and functional/mobility, or any other documentation to support the medical necessity.

Diagnosis code 4010 - The patient has malignant hypertension and requires 24-hour monitoring of their blood pressure to confirm diagnosis and regulate medication. The client has been hospitalized twice in the last 6 months (12/02/2010 and 01/15/2011) for hypertension. The client’s symptoms are (list symptoms), and the initial evaluation showed (add description).

The patient needs to monitor and record blood pressure once every hour and cannot tolerate a manual device (bruises easily).

### Section D: Dates of Service and HCPCS Codes

Enter the From: and To: dates of service for requested services.

| Dates of Service | From: | 05 / 01 / 11 | To: | 08 / 01 / 11 |
### CCP Prior Authorization Request Form Instructions

**Page 2 of 2**

**HCPCS Code/Modifier, Brief Description of Requested Services, Quantity/Frequency, and Retail Price**

Enter the appropriate and most specific HCPCS code, the appropriate modifier (if required), and brief description of the requested item or service.

Enter the appropriate quantity and frequency based on the physician’s prescription.

Enter the AWP or MSRP for DME or supplies that have no maximum fee listed in the Texas Medicaid Fee Schedule.

If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Brief Description of Requested Services</th>
<th>Quantity/Frequency</th>
<th>Retail Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9279 / U1</td>
<td>Rental of blood pressure monitoring device automatic</td>
<td>1/month</td>
<td>$40.00</td>
</tr>
</tbody>
</table>

**Note:** HCPCS codes and descriptions must be provided.

### Section E: Primary Practitioner’s Certifications

**To be completed by the prescribing physician.**

The prescribing physician must sign and date the form and print or type physician name. By signing Section E, the prescribing physician certifies the following:

- For DME and/or medical supplies the client is under 21 years of age and the DME and/or medical supplies are appropriate and can safely be used by the client when used as prescribed.
- For Private Duty Nursing, the client is under 21 years of age and the client’s medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

The prescribing physician’s TPI (if a Texas Medicaid provider), NPI, and license number must be documented. Physicians must indicate their professional license number. If the prescribing physician is out of state, the physician must provide the license number and state of professional licensure. Texas Medicaid TPI and unique physician identifier number (UPIN) numbers are not acceptable as licensure.

**Note:** Signatures from chiropractors and doctors of philosophy (PhDs) will not be accepted. Certified nurse midwife (CNM), clinical nurse specialist (CNS), nurse practitioner (NP), and physician assistant (PA) providers may sign on behalf of the physician for private duty nursing, physical, occupational and speech therapy services when the physician delegates this authority. Signature stamps and date stamps are not acceptable.

<table>
<thead>
<tr>
<th>Signature of prescribing physician:</th>
<th>A. Provider</th>
<th>Date: 04/10/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed or typed name of physician:</td>
<td>A. Provider</td>
<td></td>
</tr>
<tr>
<td>TPI: 7654321-02</td>
<td>NPI: 13572468</td>
<td>License Number: TX12345</td>
</tr>
</tbody>
</table>
### CCP Prior Authorization Request Form

*If any portion of this form is incomplete, it will be returned.*

Fax completed forms to 1-512-514-4212

#### Request for:
- [ ] DME
- [ ] Supplies
- [ ] Private Duty Nursing
- [ ] Inpatient Rehabilitation
- [ ] Other

#### Section A: Client Information

| Client Name (Last, First, MI): |  |
| Medicaid Number (PCN): | Date of Birth: / / |

#### Section B: Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information

| Supplier Name: | Telephone: | Fax Number: |
| Supplier Address: |  |
| TPI: | NPI: | Taxonomy: |
| QRP Name: | QRP TPI: | QRP NPI: |

#### Section C: Diagnosis and Medical Necessity of Requested Services

#### Section D: Dates of Service and HCPCS Code

| Dates of Service | From: / / | To: / / |
| HCPCS Code/Modifier | Brief Description of Requested Services | Quantity/Frequency | Retail Price |

Note: HCPCS codes and descriptions must be provided.

#### Section E: Primary Practitioner’s Certifications—To be completed by the primary practitioner

By prescribing the identified DME and/or medical supplies, I certify:
- The client is under 21 years of age AND
- The prescribed items are appropriate and can safely be used by the client when used as prescribed

By prescribing Private Duty Nursing, I certify:
- The client is under 21 years of age AND
- The client’s medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

Signature of prescribing physician: Date:

Printed or typed name of physician:

TPI: NPI: License Number:

Effective Date_07012011/Revised Date_05312011
CH.3    CCP Prior Authorization Private Duty Nursing 6-Month Authorization

CCP Prior Authorization Private Duty Nursing 6-Month Authorization

<table>
<thead>
<tr>
<th>Client name:</th>
<th>Client Medicaid number:</th>
<th>Date: / /</th>
</tr>
</thead>
</table>

The following criteria must be met before seeking a 6-month authorization of private duty nursing (PDN) services. Remember that authorization is a condition for reimbursement; it is not a guarantee. Each nurse provider should verify the continued Medicaid coverage for each client for each month of service.

- [ ] Client has received PDN services for at least 3 months.
- [ ] Client has had no new significant diagnosis, treatment, illness/injury or hospitalization in at least 6 months that would be expected to affect the need for PDN services.
- [ ] Client’s physician and client/parent/guardian do not anticipate any significant changes in the client’s condition for the requested authorization period.
- [ ] The nurse provider will ensure that a new physician plan of care is obtained within 30 calendar days of the authorization expiration date and will be maintained with the client’s record.
- [ ] The nurse provider will advise TMHP-CCP of any significant changes in the client’s condition, treatments or physician orders which occur during the authorization period if the number of PDN hours needs to change.
- [ ] The client’s physician, client/parent/guardian, and nurse provider understand that the authorization may be changed during the authorization period if the client’s condition or skilled needs change significantly.

**All required acknowledgments must be signed and dated**

I have read and understand the above information.

/ /  

Signature of the client/parent/guardian Date

Brief statement of why a maximum 6-month recertification is appropriate for this client:

To be completed by the client’s physician

The above services are medically necessary, the client’s condition is stable and this request supports the client’s health and safety needs.

/ /  

Signature of the client’s physician Date

Printed name:

Telephone: Fax number:

Mailing address City, State, and ZIP code

Fax completed request to TMHP-CCP at 1-512-514-4212
## CRCP Prior Authorization Request Form

### Type of Request
- [ ] CRCP – CCP services
  Fax request to 1-512-514-4212
- [ ] CRCP services
  Fax request to 1-512-514-4213

### 1. Client Information:
- **Client Name**
  - [ ] First: ________________________
  - [ ] Last: ________________________
  - [ ] Middle Initial: __________
- **Medicaid Number (PCN):** ________________________
- **Date of Birth:** / / 

### 2. Requested Service Details:
- **Primary Diagnosis:**
- **Dates of Service**
  - [ ] From: / / 
  - [ ] To: / / 
- **Procedure Code**
- **Number of Visits**
- **Frequency**

Brief description of respiratory services and goals for services provided by the CRCP:

Note: S9441 services must be performed by a Certified Asthma Educator and documentation of certification must be submitted with the request. Respiratory therapy care services that do not require the specialty of a certified respiratory care practitioner are not a benefit.

### 3. Medical Necessity Information:
For CRCP-CCP services include the reason service/education needs to be provided in the home setting and cannot be provided in the office or facility setting.
For CRCP services document why the respiratory therapy visits included in the Home Health DME rental of a ventilator or the monthly respiratory therapy visit included in the Ventilator Service Agreement would not meet the client’s medical needs.

### 4. Prescribing Physician Certifications: (To be completed by the prescribing physician)

By prescribing the CRCP services my signature below certifies the following:

**For CRCP - CCP Services**
- Client has a history of more than one emergency room or acute care clinic visits within the last three months.
- Requested service/education needs to be provided in the home setting and cannot be provided in the office or facility setting.

**For CRCP Services**
- Client wishes to be cared for at home and has adequate social support services to be cared for at home.
- Client is on a ventilator at least six hours per day.
- Client has been ventilator dependent for 30 consecutive days or more as an inpatient.
- Respiratory therapy services are in lieu of respiratory services requiring the client to remain in an inpatient care setting.

**Signature of prescribing physician:** ________________________
- **Date:** / / 

**Printed or typed name of physician:** ________________________
**Address/City/ZIP:** ________________________
**Telephone number:** ________________________
**Fax Number:** ________________________
**TPI:** ________________________
**NPI:** ________________________
**License Number:** ________________________

### 5. Billing Provider Information: (If different than the provider in Section 4)

**Provider printed name:** ________________________
- **Date:** / / 

**Contact person if Home Health agency:** ________________________
**Address/City/ZIP:** ________________________
**Telephone number:** ________________________
**Fax number:** ________________________
**TPI:** ________________________
**NPI:** ________________________

Effective Date_07012013/Revised Date_04232013
**DME Certification and Receipt Form**
Certificación y Recibo de Equipo Medico Duradero (DME)
(Page 1 of 4—Required)

This certification is required by section 32.024 of the Human Resources Code and must be completed before the DME provider can be paid for durable medical equipment provided to a Medicaid client.

Esta certificación es necesaria bajo la Sección 32.024 del Código de Recursos Humanos y se debe llenar antes de poder rembolso al proveedor del equipo médico duradero por cualquier equipo médico proporcionado al cliente de Medicaid.

<table>
<thead>
<tr>
<th>Section A: Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Medicaid ID Number:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>ZIP:</td>
</tr>
<tr>
<td>Telephone Number:</td>
</tr>
<tr>
<td>Alternate Telephone Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section B: Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
</tr>
<tr>
<td>Prior Authorization Number (PAN)</td>
</tr>
<tr>
<td>NPI/API:</td>
</tr>
<tr>
<td>TPI:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section C: Product Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section D: Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is to certify that on (month/day/year) ____________________________ the client received the ____________________________ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client’s needs.</td>
</tr>
<tr>
<td>The client, parent, or the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment’s proper use and maintenance.</td>
</tr>
<tr>
<td>Printed name of DME Supplier:</td>
</tr>
<tr>
<td>Printed name of Client, Parent, Guardian, or Primary Caregiver:</td>
</tr>
<tr>
<td>Signature of DME Supplier:</td>
</tr>
<tr>
<td>Signature of Client, Parent, Guardian, or Primary Caregiver:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section D (Optional) : Certification (Spanish)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esto certifica que el: (mes/día/año) ________________ el cliente recibió [el] [la] [los] [las] ____________________________ (equipo) que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.</td>
</tr>
<tr>
<td>El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.</td>
</tr>
<tr>
<td>Nombre del Proveedor del Equipo Medico Duradero:</td>
</tr>
<tr>
<td>Nombre del Cliente, Padre, Tutor, o Cuidador Principal:</td>
</tr>
<tr>
<td>Firma del Proveedor del Equipo Medico Duradero:</td>
</tr>
<tr>
<td>Firma del Cliente, Padre, Tutor, o Cuidador Principal:</td>
</tr>
</tbody>
</table>

Effective Date_07/01/2011/Revised Date_10/06/2011
# DME Certification and Receipt Form

Certificación y Recibo de Equipo Medico Duradero (DME)

(Page 2 of 4)

## Section E: Qualified Rehabilitation Professional (QRP) Verification for Wheeled Mobility Systems

This is to certify that on (month/day/year) ___________ the client received a wheeled mobility system or major modification to a wheeled mobility system as prescribed by the physician.

By signing this form, I verify all the following:

- I participated in the seating assessment for the wheeled mobility system or have obtained authorization to perform the fitting as the QRP, and
- The wheeled mobility system and/or major modification has been properly fitted to the client, and
- The wheeled mobility system and/or major modification meets the client’s functional needs for seating, positioning, and mobility, and
- The client, parent, guardian of the client, and/or caregiver of the client has been trained and instructed regarding the wheeled mobility system’s proper use and maintenance.

<table>
<thead>
<tr>
<th>Printed name of QRP</th>
<th>QRP TPI /NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of QRP</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This form must be submitted to TMHP for a single DME product with an allowed amount of $2500 or more, for multiple DME products submitted on the same date of service that meet or exceed a total billed amount of $2500, or for a wheeled mobility system or major modification of a wheeled mobility system. Section E must be completed for all wheeled mobility systems and major modifications to wheeled mobility systems. Submit this form with claim form or fax this form to 512-506-6615. Information submitted in this form must match the claim form.

This form must be filled out completely; place none or N/A where applicable. Incomplete forms will be returned and will cause a delay in the verification and payment process. **Failure to submit this form will affect claim payment.**

**Notice to Clients:** You may be contacted to verify receipt of the equipment provided.

**Notificación al cliente:** Puede que usted sea contactado para verificar el recibo del equipo proporcionado.

Effective Date_07/01/2011/Revised Date_10/06/2011
### DME Certification and Receipt Form

Certificación y Recibo de Equipo Medico Duradero (DME)

(Page 3 of 4—Required only for requests containing six or more items)

<table>
<thead>
<tr>
<th>Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
</tr>
<tr>
<td>Prior Authorization Number (PAN):</td>
</tr>
<tr>
<td>NPI/API:</td>
</tr>
<tr>
<td>TPI:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Information (Continuation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No.:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No.:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No.:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No.:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No.:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No.:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No.:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No.:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is to certify that on (month/day/year) ______________ the client received the ____________________________ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client's needs.</td>
</tr>
<tr>
<td>The client, parent, or the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment's proper use and maintenance.</td>
</tr>
<tr>
<td>Printed name of DME Supplier</td>
</tr>
<tr>
<td>Signature of DME Supplier</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Certification (Spanish)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esto certifica que el (mes/día/año) ________________ el cliente recibió [el] [la] [los] [las] ________________________________ (equipo) que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.</td>
</tr>
<tr>
<td>El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.</td>
</tr>
<tr>
<td>Nombre del Proveedor del Equipo Medico Duradero</td>
</tr>
<tr>
<td>Firma del Proveedor del Equipo Medico Duradero</td>
</tr>
</tbody>
</table>

Effective Date_07/01/2011/Revised Date_10/06/2011
DME Certification and Receipt Form
Certificación y Recibo de Equipo Medico Duradero (DME)
(Page 4 of 4—Not for submission to TMHP)
High Cost DME Call Verification

Your provider has sent you some medical equipment. We want to make sure that you got what you wanted and that it works well. We need to talk to you about the equipment before we can pay for it.

<table>
<thead>
<tr>
<th>Call TMHP at 1-888-276-0702.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please call us toll-free at 1-888-276-0702 as soon as you can. We are open Monday through Friday from 7 a.m. to 7 p.m., Central Time. If you call us after hours, you can leave a message. Tell us your name, phone number, and the best time to call you back.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please have this information with you when you call:</td>
</tr>
<tr>
<td>• Name</td>
</tr>
<tr>
<td>• Medicaid Number</td>
</tr>
<tr>
<td>• Birth date</td>
</tr>
<tr>
<td>• Address (street, city, state, ZIP)</td>
</tr>
<tr>
<td>• Provider’s name</td>
</tr>
<tr>
<td>• Date you got the equipment</td>
</tr>
<tr>
<td>• Details about the equipment</td>
</tr>
</tbody>
</table>
Donor Human Milk Request Form

Donor Human Milk Request Form
(Must be Reordered Every 180 Days)

Client Name: Client Medicaid Number:
Date of birth: Client’s weight:

Please include the Donor Human Milk Request Form along with the CCP Prior Authorization Request Form. Parts A and B of the Donor Human Milk Request Form must be completed and copies retained in both the physician’s and the milk bank’s records. These forms and clinical records are subject to retrospective review.

Part A

The physician must keep up-to-date documentation of medical necessity and the signed written consent form in the child’s clinical record to be considered for Medicaid reimbursement.

☐ The medical necessity for breast milk* is:

Child’s diagnosis:

Date of last feeding trial: / / 

Reason donor milk is the only appropriate source of human milk for this client:

*This information must be substantiated by written documentation in the clinical record of why the particular infant cannot survive and gain weight on any appropriate formula, such as an elemental formula or enteral nutritional product, other than donor human breast milk, and that a clinical feeding trial of an appropriate, nutritional product has been considered with each authorization.

☐ The parent/guardian has signed and dated an informed consent that the risks and benefits of using banked donor human milk has been discussed with them.

Dates of service requested From: To: Quantity Requested:

Physician’s Signature: Date: / /

Physician Name: Physician’s Fax Number:

License Number: TPI: NPI:

Part B

The particular donor human milk bank adheres to quality guidelines consistent with the Human Milk Banking Association of North America, or other standards established by HHSC.

Yes ☐ No ☐

Milk Bank Name: Milk Bank Fax Number:

Milk Bank Address:

Milk Bank Representative Signature Date: / / 

Milk Bank Representative’s Name: TPI: 

NPI: Taxonomy: Benefit Code:

Effective Date_07302007/Revised Date_04/07/2010
## External Insulin Pump Prior Authorization Form

Submit requests for a tubeless insulin pump for clients 20 years of age or younger with a completed CCP Prior Authorization Request Form or detailed orders to TMHP CCP Fax: 512- 514-4212
Submit all other requests with a completed Home Health Services (Title XIX) DME/Supplies Physician Order Form or detailed orders to TMHP Home Health Services Fax: 512-514-4209

### Client Information

<table>
<thead>
<tr>
<th>Client Name</th>
<th>Last:</th>
<th>First:</th>
<th>Middle Initial:</th>
<th>Medicaid Number:</th>
<th>Date of birth: / /</th>
</tr>
</thead>
</table>

### Prescribing Provider Information

*must be a physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife*

<table>
<thead>
<tr>
<th>Name:</th>
<th>License number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone:</td>
<td>Fax number:</td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
</tbody>
</table>

### A. Rental of External Insulin Pump

For clients diagnosed with Type 1 or Type 2 diabetes, please check which of the following conditions apply (to be considered at least two conditions must apply):

- [ ] Elevated glycosylated hemoglobin level (HbA1c) > 7.0%
- [ ] History of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
- [ ] History of severe glycemic excursions with wide fluctuations in blood glucose
- [ ] History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness
- [ ] Anticipation of pregnancy within 3 months

For clients with gestational diabetes, please check which of the following conditions apply (to be considered at least one condition must apply):

- [ ] Erratic blood sugars in spite of maximal compliance and split dosing
- [ ] Other evidence that adequate control is not being achieved by current methods

**Describe evidence if checked:**

### B. The prescribing provider signature attests to all of the following:

1. The client and/or caregiver possess the cognitive and physical abilities to follow recommended insulin pump treatment regimen, an understanding of cause and effect, and the willingness to support the use of the external insulin pump.

2. A training/education plan will be completed prior to initiation of pump therapy.

3. The client and/or caregiver will be given face-to-face education and instruction and will be able to demonstrate proficiency in integrating insulin pump therapy with their current treatment regimen for ambient glucose control.

**Prescribing Provider Signature:**

Date: / /
### CH.8 Home Health Plan of Care (POC)

Write legibly or type. Claims will be denied if POC is illegible or incomplete.

<table>
<thead>
<tr>
<th>Client’s name:</th>
<th>Date of birth: / /</th>
<th>Medicaid number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date last seen by doctor: / /</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Home Health Agency Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Fax number:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
<td>Taxonomy:</td>
</tr>
<tr>
<td>DME TPI:</td>
<td>Benefit Code:</td>
<td></td>
</tr>
</tbody>
</table>

#### Physician Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
<tr>
<td>License number:</td>
<td></td>
</tr>
<tr>
<td>Status (check one): New client ☐ Extension ☐ Revised Request ☐</td>
<td></td>
</tr>
<tr>
<td>Original SOC date: / /</td>
<td>Revised request effective date: / /</td>
</tr>
</tbody>
</table>

#### Services client receives from other agencies:

- Diagnoses (include ICD-9 codes if PT/OT is ordered):
- Function Limitations/Permitted Activities/Homebound Status:
- Prescribed medications:
  - Diet ordered:
  - Mental status:
  - Prognosis:
  - Rehabilitation potential:
- Safety Precautions:
- Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if PT/OT requested):

#### SNV visits requested:

- HHA visits requested:
- PT visits requested:
- OT visits requested:

#### Supplies:

<table>
<thead>
<tr>
<th>DME Item No. 1</th>
<th>Own ☐ Repair ☐ Buy ☐ Rent ☐</th>
<th>How long is this DME item needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>DME Item No. 2</td>
<td>Own ☐ Repair ☐ Buy ☐ Rent ☐</td>
<td>How long is this DME item needed?</td>
</tr>
<tr>
<td>DME Item No. 3</td>
<td>Own ☐ Repair ☐ Buy ☐ Rent ☐</td>
<td>How long is this DME item needed?</td>
</tr>
<tr>
<td>DME Item No. 4</td>
<td>Own ☐ Repair ☐ Buy ☐ Rent ☐</td>
<td>How long is this DME item needed?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RN signature:</th>
<th>Date signed: / /</th>
</tr>
</thead>
</table>

I anticipate home care will be required: From: / / To: / / |

#### Conflict of Interest Statement

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program. Check if this exception applies.

- ☐ Exception for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority)
- ☐ Exception for sole community Home Health Services agency as defined by 42CFR 424.22.

| Physician signature: | Date signed: / / |

Effective Date_07/30/2007/Revised Date_06/29/2007
Nursing Addendum to Plan of Care (CCP) — 1 of 7

Client name: [Client name]  Medicaid number: [Medicaid number]  Date: [Date]

Documentation Requirements

All of the following documents must be complete and received by Texas Medicaid Healthcare Partnership (TMHP) before review or authorization of PDN services can occur:

1. All components of the Nursing Addendum to Plan of Care (CCP) completed and submitted with
2. The Home Health Plan of Care (POC) form, and
3. CCP Prior Authorization Request Form (additional information may be attached).

☐ If the client is under 18 years of age, he/she must reside with an identified responsible adult/parent/guardian who is either trained to provide nursing care, or is capable of initiating an identified contingency plan when the scheduled PDN is unexpectedly unavailable.

Name: [Name]  Relationship: [Relationship]  Telephone: [Telephone]

☐ The client has an identified contingency plan.

☐ The client has a primary physician who provides ongoing health care and medical supervision.

☐ The place(s) where PDN services will be delivered supports the health and safety of the client.

☐ If applicable, there are necessary backup utilities, communication, fire, and safety systems available and functional.

1. Nursing Care Plan Summary

PDN services are based on a nursing assessment and nursing care plan established by the nurse provider in collaboration with the physician, client, and family. The nursing care plan provides a systematic way to document care given, client responses to interventions, and progress toward the goals of care.

Problem list:

<table>
<thead>
<tr>
<th>Problem list</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Goals of care:

<table>
<thead>
<tr>
<th>Goals of care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Specific measurable outcomes:

<table>
<thead>
<tr>
<th>Specific measurable outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Progress toward goals:

<table>
<thead>
<tr>
<th>Progress toward goals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Additional comments:

<table>
<thead>
<tr>
<th>Additional comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Effective Date_09012007/Revised Date_04072010
**Nursing Addendum to Plan of Care (CCP)—2 of 7**

<table>
<thead>
<tr>
<th>Client name:</th>
<th>Medicaid number:</th>
<th>Date: / /</th>
</tr>
</thead>
</table>

2. **Summary of Recent Health History**—For initial authorization or 90-day summary for extension of PDN services

Include recent hospitalizations, emergency room visits, surgery (may submit a discharge summary), illnesses, changes in condition, changes in medication or treatment, parent/guardian update, other pertinent observations.

3. **Rationale for PDN Hours**—To either increase, decrease, or stay the same. Also address plans to decrease PDN hours.
**Nursing Addendum to Plan of Care (CCP)—3 of 7**

<table>
<thead>
<tr>
<th>Client name:</th>
<th>Medicaid number:</th>
<th>Date: / /</th>
<th>Client/parent/guardian initials:</th>
</tr>
</thead>
<tbody>
<tr>
<td>List other in-home resources:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Schedule of Services 24-hour Daily Flow Sheet, 00:00—05:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, O=other in-home resource(s), specify name above

<table>
<thead>
<tr>
<th>Military Time</th>
<th>Sunday</th>
<th>Provider</th>
<th>Monday</th>
<th>Provider</th>
<th>Tuesday</th>
<th>Provider</th>
<th>Wednesday</th>
<th>Provider</th>
<th>Thursday</th>
<th>Provider</th>
<th>Friday</th>
<th>Provider</th>
<th>Saturday</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>00:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>00:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>00:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>00:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>03:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>03:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>03:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>03:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>04:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>04:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>04:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>04:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Nursing Addendum to Plan of Care (CCP)—4 of 7

<table>
<thead>
<tr>
<th>Military Time</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>06:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>07:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>07:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>07:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>07:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>08:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>08:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>08:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>08:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>09:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>09:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>09:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>09:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### List other in-home resources

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

**Codes:**
- N=PDN hours
- P=family (if family has volunteered)
- S=school/daycare
- O=other in-home resource(s), specify name above
Nursing Addendum to Plan of Care (CCP)—5 of 7

Client name:  
Medicaid number:  
Date: / /  
Client/parent/guardian initials:  

List other in-home resources:

4. Schedule of Services 24-hour Daily Flow Sheet, 12:00—17:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.  
Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, O=other in-home resource(s), specify name above

<table>
<thead>
<tr>
<th>Military Time</th>
<th>Sunday Provider</th>
<th>Monday Provider</th>
<th>Tuesday Provider</th>
<th>Wednesday Provider</th>
<th>Thursday Provider</th>
<th>Friday Provider</th>
<th>Saturday Provider</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Nursing Addendum to Plan of Care (CCP)—6 of 7**

<table>
<thead>
<tr>
<th>Client name:</th>
<th>Medicaid number:</th>
<th>Date: / /</th>
<th>Client/parent/guardian initials:</th>
</tr>
</thead>
<tbody>
<tr>
<td>List other in-home resources:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 4. Schedule of Services 24-hour Daily Flow Sheet, 18:00—23:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

**Codes:**
- N=PDN hours
- P=family (if family has volunteered)
- S=school/daycare
- O=other in-home resource(s), specify name above

<table>
<thead>
<tr>
<th>Military Time</th>
<th>Sunday Provider</th>
<th>Monday Provider</th>
<th>Tuesday Provider</th>
<th>Wednesday Provider</th>
<th>Thursday Provider</th>
<th>Friday Provider</th>
<th>Saturday Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>18:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23:15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Nursing Addendum to Plan of Care (CCP)—7 of 7

<table>
<thead>
<tr>
<th>Client name:</th>
<th>Medicaid number:</th>
<th>Date:</th>
</tr>
</thead>
</table>

#### 5. Acknowledgement

**Must be signed by the client/parent/guardian and the nurse provider.**

By signing this form, the client/parent/guardian and the nurse provider acknowledge:

- Discussion and receipt of information about the CCP Private Duty Nursing service,
- PDN services may increase, decrease, stay the same, or be terminated based on a client’s need for skilled care,
- PDN is not authorized for respite, child care, activities of daily living, or housekeeping,
- All required criteria from the first page of this addendum are met, and completed documentation is submitted to TMHP,
- Participation in the development of the Nursing Care Plan for this client, and
- Emergency plans are part of the client’s care plan and include telephone numbers for the client’s physician, ambulance, hospital, and equipment supplier and information on how to handle emergency situations.

The client/parent/guardian agrees to follow through with the plan of care as prescribed by the client’s physician.

<table>
<thead>
<tr>
<th>Number of PDN hours requested</th>
<th>Hours per day:</th>
<th>or</th>
<th>Hours per week:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates of service from:</td>
<td>/ /</td>
<td>to</td>
<td>/ /</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of client/parent/guardian</th>
<th>Printed name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ /</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of PDN nurse provider</th>
<th>Printed name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ /</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of prescribing physician</th>
<th>Printed name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ /</td>
<td></td>
</tr>
</tbody>
</table>
# Pulse Oximeter Form

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Medicaid number:</th>
</tr>
</thead>
</table>

## DME Provider Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
<th>Fax number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>NPI:</td>
<td></td>
</tr>
<tr>
<td>TPI:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taxonomy:</td>
<td>Benefit Code:</td>
<td></td>
</tr>
</tbody>
</table>

## Equipment Information

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Product Name and Model Number</th>
<th>Retail Price</th>
</tr>
</thead>
</table>

New device provided for purchase? ☐ Yes ☐ No

---

### Equipment designated for clinical use only is not considered appropriate for use in the home

**Note:** Oxygen dependent is defined as ongoing, regular need for use of supplemental oxygen for a portion of the day to maintain oxygen saturation. This does not include: PRN use; use only when sick; use only when suctioning; use for desaturation that occurs only when crying; use for desaturation that occurs only with seizure activity.

## The following information must be completed by the physician

**Diagnosis and Basis for Medical Necessity of requested services:**

---

### Dates of Service requested for Prior Authorization

From: / /  To: / /

- ☐ Client is ventilator and or oxygen dependent
- ☐ Client is ventilator dependent  hours per day
- ☐ Client is on oxygen for  hours per day
- ☐ Client is weaning from oxygen and or a ventilator
- ☐ Anticipated length of monitor need: ☐ Months: ☐ 1-3 years ☐ More than 3 years
- ☐ Who will respond to the monitor alarm?
- ☐ Can the client’s medical needs be met with intermittent “spot check” of oxygen saturations? ☐ Yes ☐ No
- ☐ What is the medical basis for need of continuous monitoring?

---

### Is the client receiving any nursing services such as PDN, Home Health Visits, MDCP, CBA, or Private Insurance?

Please indicate services:

Number of hours/visits:

- ☐ Is the client in compliance with the hours of oxygen therapy ordered? ☐ Yes ☐ No

## Physician Information

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (printed):</td>
<td>Telephone:</td>
</tr>
<tr>
<td>Address:</td>
<td>NPI:</td>
</tr>
<tr>
<td>TPI:</td>
<td>License number:</td>
</tr>
</tbody>
</table>

---

*Must be submitted with a THSteps-CCP Prior Authorization Request Form*

Effective Date_01012009/Revised Date_05012012
# Request for Initial Outpatient Therapy (Form TP-1)

**CCP - Texas Medicaid & Healthcare Partnership**
PO Box 200735
Austin TX 78720-0735
1-800-846-7470
CCP FAX: 1-512-514-4212

**Texas Medicaid & Healthcare Partnership**
CSHCN
PO Box 200855
Austin TX 78720-0855
1-800-568-2413 or 1-512-514-3000
FAX: 1-512-514-4222

<table>
<thead>
<tr>
<th>Medicaid Number:</th>
<th>CSHCN Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name:</td>
<td>Date of birth:</td>
</tr>
<tr>
<td>Address:</td>
<td>Telephone:</td>
</tr>
</tbody>
</table>

Has the child received therapy in the last year from the public school system? □ Yes □ No

Date of Initial Evaluation: PT OT SLP

* A copy of the initial evaluation must be attached

**ICD-9 Code/Diagnosis:**
**Date of onset:**

### Category of Therapy Being Requested

- **PT/OT for:**
  - □ Developmental anomalies
  - □ Pre-surgery
  - □ Post-surgery
  - Date of surgery: / / 

- □ Cast Removal
  - Date Removed: / / 

- □ Serial Casting
- □ Acute Episode of Chronic Condition

- □ New Condition
- □ Specialty Clinic
- □ Home Program
- □ ADL (activities of daily living)
- □ Equipment Assessment
- □ Equipment Training

**Speech for:**
- □ Craniofacial
- □ Developmental Anomalies
- □ New Condition
- □ Post Cochlear Implant

### Check the service requested, indicate the date(s) of service and frequency per week or month:

Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service Date(s)</th>
<th>Frequency per week</th>
<th>Frequency per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ PT</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>☐ OT</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>☐ SLP</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
</tbody>
</table>

**Procedure code(s) for therapy services:**

**Specialist Name:**
**Signature:**
**Date Signed:**

- **Physician:**
- **PT Therapist:**
- **OT Therapist:**
- **SLP Therapist:**

### Provider Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
<th>Fax:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medicaid Identifying Information**

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
</tr>
</thead>
</table>

**CSHCN Identifying Information**

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
</tr>
</thead>
</table>

- **FOR OFFICE USE ONLY:**
  - Medicaid □ Yes □ No
  - HMO □ Yes □ No
  - Restrictions:
  - PAN# Valid To

Effective Date: 07/30/2007/Revised Date: 06/01/2007
# CH.12 Request for Extension of Outpatient Therapy (Form TP-2) (2 Pages)

## Request for Extension of Outpatient Therapy (Form TP-2)

<table>
<thead>
<tr>
<th>Category of Therapy Being Requested</th>
<th>PT/OT for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Developmental anomalies</td>
<td>☐ Pre-surgery</td>
</tr>
<tr>
<td>☐ Cast Removal</td>
<td>☐ Post-surgery</td>
</tr>
<tr>
<td>☐ New Condition</td>
<td>☐ Date of surgery</td>
</tr>
<tr>
<td>☐ Serial Casting</td>
<td>☐ Date Removed</td>
</tr>
<tr>
<td>☐ Equipment Assessment</td>
<td>☐ Specialty Clinic</td>
</tr>
<tr>
<td>☐ Equipment Training</td>
<td>☐ Home Program</td>
</tr>
<tr>
<td>☐ Speech for:</td>
<td>☐ ADL (activities of daily living)</td>
</tr>
<tr>
<td>☐ Craniofacial</td>
<td>☐ Post Cochlear Implant</td>
</tr>
<tr>
<td>☐ Developmental Anomalies</td>
<td>☐ New Condition</td>
</tr>
<tr>
<td>☐ Post-surgery</td>
<td>☐ PT</td>
</tr>
<tr>
<td>☐ Craniofacial</td>
<td>☐ OT</td>
</tr>
<tr>
<td>☐ New Condition</td>
<td>☐ SLP</td>
</tr>
<tr>
<td>☐ Equipment Assessment</td>
<td>☐ Equipment Training</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Check the service requested, indicate the date(s) of service and frequency per week or month:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.</td>
</tr>
<tr>
<td>Service Type</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>☐ PT</td>
</tr>
<tr>
<td>☐ OT</td>
</tr>
<tr>
<td>☐ SLP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure code(s) for therapy services:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Specialist</th>
<th>Name</th>
<th>Signature</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td></td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>PT Therapist</td>
<td></td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>OT Therapist</td>
<td></td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>SLP Therapist</td>
<td></td>
<td>/ /</td>
<td></td>
</tr>
</tbody>
</table>

## Provider Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
<th>Fax:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Medicaid Identifying Information

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
</tr>
</thead>
</table>

## CSHCN Identifying Information

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
</tr>
</thead>
</table>

FOR OFFICE USE ONLY: Medicaid ☐ Yes ☐ No HMO ☐ Yes ☐ No Restrictions:

Effective Date_07302007/Revised Date_06012007

FORM TP-2 Page 1 of 2
<table>
<thead>
<tr>
<th>PAN#</th>
<th>Valid</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Number:</td>
<td>CSHCN Number:</td>
<td></td>
</tr>
<tr>
<td>Client Name:</td>
<td>Date of birth: / /</td>
<td></td>
</tr>
<tr>
<td>Current Functional Status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Treatment Goals:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Dates of Service: from / / to / /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Functional Status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Treatment Goals:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Treatment Provided:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FORM TP-2 Page 2 of 2
Effective Date_07302007/Revised Date_06012007
### THSteps Dental Mandatory Prior Authorization Request Form

**If any portion of this form is incomplete and/or missing any required documentation, it will be returned.**

<table>
<thead>
<tr>
<th>Client Name (Last, First, MI):</th>
<th>Medicaid Number (PCN):</th>
<th>Date of Birth: / /</th>
</tr>
</thead>
</table>

- [ ] Restorative
- [ ] Intermediate Care Facility for the Mentally Retarded (ICF-MR)

**NOTE:** Check all documentation submitted for review with the prior authorization request.

- [ ] Panorex  [ ] FM X-ray  [ ] Periapicals  [ ] Photos  [ ] Other Documentation

- [ ] Orthodontic Services

**NOTE:** Check all documentation submitted for review with the prior authorization request.

- [ ] Plaster cast models  [ ] HLD  [ ] Panorex  [ ] Cephalometric X-ray with tracing  [ ] FM X-ray  

- [ ] Photos  [ ] Other Documentation (please specify)

**Date of Service Diagnostic Tools Were Produced:** / /

**Proposed Treatment Plan**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Tooth Number or Letter</th>
<th>Surface</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Dentist’s Certifications—To be completed by the performing dentist.**

**By checking the boxes below and signing this form:**

- [ ] I certify all radiographs, photographs, and other documentation of medical necessity for the requested services are unaltered.

- [ ] I certify I have discussed all treatment options with the client and parent or legal guardian, including the recommended surgical treatment plan. I have addressed the client's risks if the treatment plan is not followed to completion and explained the treatment plan should not be started if the family does not agree to this course of treatment.

- [ ] I certify all primary dentition have been exfoliated (D8080).

I certify I have one of the following designations from the Texas Board of Dental Examiners, or I meet the continuing education requirements to provide orthodontic services:

- [ ] Board certified or board eligible pediatric dentist.
- [ ] Board certified or board eligible orthodontist.

- [ ] General dentist attesting to completion of a minimum of 200 continuing dental education hours in orthodontics, only 8 hours can be online or self-instruction.

**NOTE:** Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services, but documentation must be produced by the dentist during retrospective review.

<table>
<thead>
<tr>
<th>Signature of performing dentist:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed or typed name of dentist:</td>
<td>Dentist telephone:</td>
</tr>
<tr>
<td>Address:</td>
<td>Fax:</td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
<tr>
<td>Taxonomy:</td>
<td>Benefit Code:</td>
</tr>
</tbody>
</table>

Effective Date_03/01/2012/Revised Date_08/07/2012
Criteria for Dental Therapy Under General Anesthesia

Total points needed to justify treatment under general anesthesia = 22.

<table>
<thead>
<tr>
<th>Age of client at time of examination</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than four years of age</td>
<td>8</td>
</tr>
<tr>
<td>Four and five years of age</td>
<td>6</td>
</tr>
<tr>
<td>Six and seven years of age</td>
<td>4</td>
</tr>
<tr>
<td>Eight years of age and older</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Requirements (Carious and/or Abscessed Teeth)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 teeth or one sextant</td>
<td>3</td>
</tr>
<tr>
<td>3-4 teeth or 2-3 sextants</td>
<td>6</td>
</tr>
<tr>
<td>5-8 teeth or 4 sextants</td>
<td>9</td>
</tr>
<tr>
<td>9 or more teeth or 5-6 sextants</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavior of Client**</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely negative—unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability</td>
<td>10</td>
</tr>
<tr>
<td>Somewhat negative—defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator’s hand; refusal to take radiographs</td>
<td>4</td>
</tr>
<tr>
<td>Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal responses and are not indications for treatment under general anesthesia</td>
<td>0</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

<table>
<thead>
<tr>
<th>Additional Factors**</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention**</td>
<td>15</td>
</tr>
<tr>
<td>Failed conscious sedation**</td>
<td>15</td>
</tr>
<tr>
<td>Medically compromising of handicapping condition**</td>
<td>15</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

I understand and agree with the dentist’s assessment of my child’s behavior.

PARENT/GUARDIAN SIGNATURE: ____________________________________________________ DATE: ________________

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the client’s chart. The client’s chart must be available for review by representatives of TMHP and/or HHSC.

PERFORMING DENTIST’S SIGNATURE: ________________________________________________

DATE: ___________________________ License No. ____________________________

Effective Date_01012009/Revised Date_12172008
Medicaid Dental Policy Regarding Criteria for Dental Therapy
Under General Anesthesia–Attachment 1

Purpose: To justify I.V. Sedation or General Anesthesia for Dental Therapy, the following documentation is required in the Child’s Dental Record.

Elements: Note those required* and those as appropriate**:

1) The medical evaluation justifying the need for anesthesia
2) Description of relevant behavior and reference scale
3) Other relevant narrative justifying the need for general anesthesia.
4) Client’s demographics, including date of birth.
5) Relevant dental and medical history.
6) Dental radiographs, intraoral\perioral photography and/or diagram of dental pathology.
7) Proposed Dental Plan of Care.
8) Consent signed by parent\guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained.
10) The parent/guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist’s assessment of their child’s behavior.
11) Dentist’s attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand alone form.

“I attest that the client’s condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the client’s record and is available in my office.”

REQUESTING DENTIST’S SIGNATURE: ____________________________ DATE: ________________

Effective Date_01012009/Revised Date_12172008
CH.15  THSteps Referral Form Instructions

The referral form assists in relaying correct and pertinent information to the person or agency receiving the referral. It may be mailed or hand-carried by the client. When the form is returned, it should be placed in the client’s record.

Receiving/Referring Agencies
The name and address of both agencies should be completed to allow communication if additional information is necessary and to return a completed referral. If the referral is to a physician and the client is not able to name the physician who will be seen, this space may be completed MD/DO.

Identifying Information
This section concerning patient information should be as complete as possible. This section will assist the receiving agency to locate the client.

Reason for Referral
This section should contain information which is relevant to the referral. It may contain an assessment with request for further evaluation, or a request for intervention by a physician, hospital, or other agency involved with the client. Other information pertinent to the referral, such as family history or involvement with other agencies, may also be included.

Release of Information
This section must be signed.

Findings/Services Rendered
This final section provided the receiving agency the vehicle with which to transmit information back to originator of referral. Form may be mailed or carried by the client.
CH.16   THSteps Referral Form

Referral date:_______________________

__________________________

TO: Name and address of receiving agency or person

FROM: Name and address of person or referring agency

__________________________

Client’s name:_______________________ Social Security number:__________________

Address:__________________________ Birth date:__________ Sex: (M)____(F)____

Telephone:__________________________ DIRECTIONS TO HOME:__________________

Name of spouse/parent/guardian ____________________________


REASON FOR REFERRAL:

________________________________________________________________________

RETURN RESPONSE REQUESTED

Signature/Title

Signature signifies receipt/knowledge of this referral and authorizes the referring agency to release information necessary for its completion, and the referring agency is released from all legal responsibility that may arise from this act.

________________________________________________________________________

Signature of Client/Parent/Guardian

FINDINGS AND SERVICES RENDERED:

________________________________________________________________________

1) White - Receiving Agency  Signature/Title

2) Yellow - Receiving Agency Response

3) Pink - Client Record  Date

Note: Instructions (L-29a) for use of Referral Form should accompany the document. (HHSC) L-29 Rev. (6/91)
CH.17  CCP Prior Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services (2 Pages)

Use this form for dates of service on or after January 1, 2009.

**CCP Prior Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services (2 Pages)**

<table>
<thead>
<tr>
<th>Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name:</td>
</tr>
<tr>
<td>Medicaid number (PCN):</td>
</tr>
<tr>
<td>Address, city, and ZIP:</td>
</tr>
<tr>
<td>Diagnosis codes (ICD-9-CM):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>I attest that this client’s health care is medically complex and multidisciplinary.</td>
</tr>
<tr>
<td>Medically complex is the health care needed by a Medicaid beneficiary achieves the designation of “medically complex” when the approved plan of care necessitates a clinical professional, practicing within the scope of their license and in the context of a medical home, coordinate ongoing treatment to ensure its safe and effective delivery.</td>
</tr>
<tr>
<td>Multidisciplinary Care is the coordination of clinician ordered medically necessary health care that requires the collaboration of two or more medical, educational, social, developmental or other professionals in order to properly devise and implement the clinician-developed plan of medical care. For Medicaid coverage, multidisciplinary health care must include medically necessary services provided by program-enrolled clinical providers. Development and implementation of the plan of medical care may, in addition, need to take into account other related care provided by nonclinical providers as required to address the overall health needs of a client.</td>
</tr>
</tbody>
</table>

| DATE of my last Face-to-Face inpatient or outpatient evaluation and management visit with the client: ____/____/____ |

| I request a six-month authorization from ____/____/____ to _____/____/_____ for non-face-to-face care coordination services for the client named on this form. I attest that these services are essential to provide quality health care for the identified client. I request authorization for the following types of services in the stated six-month period (check all that apply): |
| Care plan oversight: |
| Home or other Home health** Hospice** Nursing Facility |
| 99339  99374  99377  99379 |
| 99340  99375  99378  99380 |

* I understand that I may submit a statement of medical necessity or progress note with a claim or with this authorization form for consideration of authorization of services that exceed the Texas Medicaid Program limits indicated above. Documentation must support a significant change in the client’s clinical condition. |

** I attest that I am the clinician who signed the plan of care for the home health agency or hospice; I do not have a significant financial or contractual relationship with the home health agency or hospice. I am not the medical director or employee of the hospice; and I do not furnish services under any arrangement with the hospice (including volunteering). |

| Team conferences (authorization and reimbursement are limited to a maximum of one service per six-month authorization period. Authorization of additional team conferences may be considered for a client when there is documentation on this form of a change in the client’s medical home provider.): |
| 99367 |

Effective Date_10/24/2008/Revised Date_04/07/2010
Client Information

<table>
<thead>
<tr>
<th>First name:</th>
<th>Last name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medicaid number (PCN):

Certification (continued)

I attest that I am the medical home provider for the client and, as such, in coordination with the family and client, I have generated or updated (within the prior 12 months), a comprehensive care plan for the client which is documented in the client’s medical record, has been shared with the family or client, and includes the following components, at a minimum:

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

Documentation

One of the following forms of documentation must be submitted with this request in order to obtain prior authorization for non-face-to-face care coordination services:

- Formal and written care plan.
- A progress note detailing care coordination planning and activities.
- A letter stating medical necessity for care coordination, including information on the care plan and care coordination services.

Provider Information

Clinician provider name:

<table>
<thead>
<tr>
<th>Medicaid TPI:</th>
<th>NPI:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Taxonomy code:</th>
<th>Benefit code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone number:</th>
<th>Fax number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address, city, and ZIP:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Clinician provider signature: Date: ____/____/_____

Effective Date_10/24/2008/Revised Date_04/07/2010
### Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services–Comprehensive Care Program (CCP)

Use this form for dates of service on or after January 1, 2009.

#### Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services–Comprehensive Care Program (CCP)

<table>
<thead>
<tr>
<th>(Specialist must keep form on file)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Medicaid number:            Date: <em><strong>/</strong></em>/____</td>
</tr>
<tr>
<td>Client name:                       Time call started:</td>
</tr>
<tr>
<td>Date of birth: <em><strong>/</strong></em>/____         Time call ended:</td>
</tr>
</tbody>
</table>

Parts A and B of this form must be completed and the form retained in the specialist’s or subspecialist’s records. This form is subject to retrospective review.

#### Part A

Reason for call:

The specialist’s or subspecialist’s medical opinion:

Recommended treatment or laboratory services:

<table>
<thead>
<tr>
<th>Physician’s signature:            Date: <em><strong>/</strong></em>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician name:                   Physician’s fax number:</td>
</tr>
<tr>
<td>TPI: NPI: Taxonomy:</td>
</tr>
</tbody>
</table>

#### Part B

<table>
<thead>
<tr>
<th>Referring medical home clinician:</th>
<th>Referring clinician’s telephone number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPI: NPI: Taxonomy:</td>
<td></td>
</tr>
</tbody>
</table>

Effective Date_10/24/2008/Revised Date_03/18/2008
**CH.19  Wheelchair/Scooter/Stroller Seating Evaluation Form (CCP/Home Health Services) (7 Pages)**

### Instructions

A current wheelchair/scooter/stroller seating assessment conducted by a physician or a physical or occupational therapist must be completed for purchase of or major modifications (including new seating systems) to a wheeled mobility system. A Qualified Rehabilitation Professional (QRP) must be present and participate in the seating assessment for all wheeled mobility systems and major modifications.

Please attach manufacturer information, descriptions, and an itemized list of retail prices of all additions that are not included in base model price.


### Client Information

<table>
<thead>
<tr>
<th>First name:</th>
<th>Last name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid number:</td>
<td>Date of birth:</td>
</tr>
</tbody>
</table>

**Diagnosis:**

| Height: | Weight: |

### I. Neurological Factors

- Indicate client’s muscle tone: [ ] Hypertonic  [ ] Absent  [ ] Fluctuating  [ ] Other
- Describe client’s muscle tone:

Describe active movements affected by muscle tone:

Describe passive movements affected by muscle tone:

Describe reflexes present:
II. Postural Control

<table>
<thead>
<tr>
<th>Head control:</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trunk control:</td>
<td>Good</td>
<td>Fair</td>
<td>Poor</td>
<td>None</td>
</tr>
<tr>
<td>Upper extremities:</td>
<td>Good</td>
<td>Fair</td>
<td>Poor</td>
<td>None</td>
</tr>
<tr>
<td>Lower extremities:</td>
<td>Good</td>
<td>Fair</td>
<td>Poor</td>
<td>None</td>
</tr>
</tbody>
</table>

III. Medical/Surgical History And Plans:

Is there history of decubitis/skin breakdown?  ☐ Yes  ☐ No

If yes, please explain:

Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures, degree of spinal curvature, etc.):

Describe other physical limitations or concerns (i.e., respiratory):

Describe any recent or expected changes in medical/physical/functional status:

If surgery is anticipated, please indicate the procedure and expected date:

IV. Functional Assessment:

<table>
<thead>
<tr>
<th>Ambulatory status:</th>
<th>Nonambulatory</th>
<th>With assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Short distances only</td>
<td>Community ambulatory</td>
</tr>
<tr>
<td>Indicate the client’s ambulation potential:</td>
<td>Expected within 1 year</td>
<td>Not expected</td>
</tr>
<tr>
<td></td>
<td>Expected in future within ___ years</td>
<td></td>
</tr>
</tbody>
</table>
### IV. Functional Assessment:

**Wheelchair Ambulation:**

- Is client totally dependent upon wheelchair?  
  - Yes  
  - No

*If no, please explain:*

**Indicate the client’s transfer capabilities:**

- Maximum assistance
- Minimum assistance
- Moderate assistance
- Independent

**Is the client tube fed?**

*If yes, please explain:*

- Yes  
- No

**Feeding:**

- Maximum assistance
- Minimum assistance
- Moderate assistance
- Independent

**Dressing:**

- Maximum assistance
- Minimum assistance
- Moderate assistance
- Independent

**Describe other activities performed while in wheelchair:**

### V. Environmental Assessment

**Describe where client resides:**

**Is the home accessible to the wheelchair?**

- Yes  
- No

**Are ramps available in the home setting?**

- Yes  
- No

**Describe the client’s educational/vocational setting:**

**Is the school accessible to the wheelchair?**

- Yes  
- No

**Are there ramps available in the school setting?**

- Yes  
- No

**If client is in school, has a school therapist been involved in the assessment?**

- Yes  
- No

**Name of school therapist:**

**Name of school:**
V. Environmental Assessment

School therapist’s telephone number:

Describe how the wheelchair will be transported:

Describe where the wheelchair will be stored (home and/or school):

Describe other types of equipment which will interface with the wheelchair:

VI. Requested Equipment:

Describe client’s current seating system, including the mobility base and the age of the seating system:

Describe why current seating system is not meeting client’s needs:

Describe the equipment requested:

Describe the medical necessity for mobility base and seating system requested:

Describe the growth potential of equipment requested in number of years:

Describe any anticipated modifications/changes to the equipment within the next three years:

VII: Signatures of Therapist/Physician and Qualified Rehabilitation Professional (QRP)

Physician/Therapist’s name:           Physician/Therapist’s signature:
Physician/Therapist’s title:           Date:
Physician/Therapist’s telephone number: (       ) -
<table>
<thead>
<tr>
<th><strong>Physician/Therapist’s employer (name):</strong></th>
<th><strong>Physician/Therapist’s address (work or employer address):</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>QRP Name:</td>
<td>NPI: TPI:</td>
</tr>
<tr>
<td>QRP Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

**VIII. POWER WHEELCHAIRS:**
*Complete if a power wheelchair is being requested*

Describe the medical necessity for power vs. manual wheelchair:
*(Justify any accessories such as power tilt or recline)*

<table>
<thead>
<tr>
<th><strong>Is client unable to operate a manual chair even when adapted?</strong></th>
<th><strong>Yes</strong></th>
<th><strong>No</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is self propulsion possible but activity is extremely labored?</strong></td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td><em>If yes, please explain:</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Is self propulsion possible but contrary to treatment regimen?</strong></td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td><em>If yes, please explain:</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How will the power wheelchair be operated (hand, chin, etc.)?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Has the client been evaluated with the proposed drive controls?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Does the client have any condition that will necessitate possible change in access or drive controls within the next five years?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Is the client physically and mentally capable of operating a power wheelchair safely and with respect to others?</strong></td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>Is the caregiver capable of caring for a power wheelchair and understanding how it operates?</strong></td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>How will training for the power equipment be accomplished?</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### IX: Signatures of Therapist/Physician and Qualified Rehabilitation Professional (QRP)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Therapist’s name</td>
<td>Physician/Therapist’s signature:</td>
<td></td>
</tr>
<tr>
<td>Physician/Therapist’s title</td>
<td></td>
<td>Date:</td>
</tr>
<tr>
<td>Physician/Therapist’s telephone number</td>
<td>(    ) -</td>
<td></td>
</tr>
<tr>
<td>Physician/Therapist’s employer (name):</td>
<td></td>
<td>Physician/Therapist’s address (work or employer address):</td>
</tr>
<tr>
<td>QRP Name:</td>
<td>NPI:</td>
<td>TPI:</td>
</tr>
<tr>
<td>QRP Signature:</td>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>
## Home Health/CCP Measuring Worksheet

### General Information

<table>
<thead>
<tr>
<th>Client's name:</th>
<th>Date of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client's Medicaid number:</td>
<td>Height:</td>
</tr>
<tr>
<td>Date when measured:</td>
<td>Weight:</td>
</tr>
</tbody>
</table>

### Measurements

<table>
<thead>
<tr>
<th>Number</th>
<th>Measurement Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:</td>
<td>Top of head to bottom of buttocks</td>
</tr>
<tr>
<td>2:</td>
<td>Top of shoulder to bottom of buttocks</td>
</tr>
<tr>
<td>3:</td>
<td>Arm pit to bottom of buttocks</td>
</tr>
<tr>
<td>4:</td>
<td>Elbow to bottom of buttocks</td>
</tr>
<tr>
<td>5:</td>
<td>Back of buttocks to back of knee</td>
</tr>
<tr>
<td>6:</td>
<td>Foot length</td>
</tr>
<tr>
<td>7:</td>
<td>Head width</td>
</tr>
<tr>
<td>8:</td>
<td>Shoulder width</td>
</tr>
<tr>
<td>9:</td>
<td>Arm pit to arm pit</td>
</tr>
<tr>
<td>10:</td>
<td>Hip width</td>
</tr>
<tr>
<td>11:</td>
<td>Distance to bottom of left leg (popliteal to heel)</td>
</tr>
<tr>
<td>12:</td>
<td>Distance to bottom of right leg (popliteal to heel)</td>
</tr>
</tbody>
</table>

### Additional Comments


### Signatures of Measurer and Qualified Rehabilitation Professional (QRP)

<table>
<thead>
<tr>
<th>Measurer's Name</th>
<th>Measurer's Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

Measurer's Telephone number: ( ) -

QRP Name:  

<table>
<thead>
<tr>
<th>QRP Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>
9. CLAIM FORM EXAMPLES
### Comprehensive Outpatient Rehabilitation Facility (CORF) (CCP Only)

**Rehabilitation Health Center**

2600 West Drive  
Texarkana, TX 75503  
903-555-1234

**Patient Information**

- **Name:** Doe, Jane  
- **Address:** 9504 Dale St., Houston, TX 77057

**Certifications:** The certifications on the reverse apply to this bill and are made a part hereof.

**Patient Information**

- **Birth Date:** 03/24/1996  
- **Sex:** F  
- **Race:** 01  
- **State:** TX

**Diagnosis Information**

- **DX Reason:** Hemplegia, Spastic

**Procedure Information**

1. **Comp. Outpatient Therapy Eval.**  
   - **Date:** 01/23/2013  
   - **Code:** 97001  
   - **Amount:** $40.00

2. **Speech Therapy**
   - **Date:** 01/25/2013  
   - **Code:** 97526 GN  
   - **Amount:** $50.00

3. **Physical Therapy**
   - **Date:** 01/29/2013  
   - **Code:** 97110 GP  
   - **Amount:** $45.00

**Total Charges:** $135.00

---

**CPT - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.**
**CH.21 Diagnosis and Treatment (Referral from THSteps Checkup)**

**HEALTH INSURANCE CLAIM FORM**

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

<table>
<thead>
<tr>
<th>ITEM</th>
<th>CONTENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a.</td>
<td>INSURED'S I.D. NUMBER (For Program in Item 1) 123456789</td>
</tr>
<tr>
<td>4.</td>
<td>INSURED'S NAME (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>5.</td>
<td>PATIENT'S ADDRESS (No., Street) 2608 Best Street</td>
</tr>
<tr>
<td>6.</td>
<td>PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other</td>
</tr>
<tr>
<td>7.</td>
<td>INSURED'S ADDRESS (No., Street)</td>
</tr>
<tr>
<td>7a.</td>
<td>NAME OF REFERRING PROVIDER OR OTHER SOURCE Sidney Medical Clinic</td>
</tr>
<tr>
<td>8.</td>
<td>OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John</td>
</tr>
<tr>
<td>9.</td>
<td>OTHER INSURED'S I.D. NUMBER (For Program in Item 1) 1234560987</td>
</tr>
<tr>
<td>10.</td>
<td>INSURED'S DATE OF BIRTH 04 09 1994</td>
</tr>
<tr>
<td>11.</td>
<td>INSURED'S POLICY GROUP OR FECA NUMBER 71010</td>
</tr>
<tr>
<td>12.</td>
<td>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the undersigned physician or supplier for services described below.</td>
</tr>
<tr>
<td>13.</td>
<td>INSURED'S I.D. NUMBER</td>
</tr>
<tr>
<td>15.</td>
<td>IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. YES NO</td>
</tr>
<tr>
<td>16.</td>
<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY</td>
</tr>
<tr>
<td>18.</td>
<td>MEDICARE</td>
</tr>
<tr>
<td>19.</td>
<td>RESERVED FOR LOCAL USE</td>
</tr>
<tr>
<td>20.</td>
<td>OUTSIDE LAB? $ CHARGES</td>
</tr>
<tr>
<td>21.</td>
<td>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</td>
</tr>
<tr>
<td>22.</td>
<td>MEDICARE RESUBMISSION CODE</td>
</tr>
<tr>
<td>23.</td>
<td>PRIOR AUTHORIZATION NUMBER</td>
</tr>
<tr>
<td>24.</td>
<td>PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</td>
</tr>
<tr>
<td>25.</td>
<td>FEDERAL TAX I.D. NUMBER</td>
</tr>
<tr>
<td>28.</td>
<td>PATIENT'S ACCOUNT NO. 1234567890</td>
</tr>
<tr>
<td>29.</td>
<td>ACCEPT ASSIGNMENT FOR GOVT. CLAIMS, SEE BACK</td>
</tr>
<tr>
<td>30.</td>
<td>BALANCE DUE</td>
</tr>
<tr>
<td>31.</td>
<td>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</td>
</tr>
<tr>
<td>32.</td>
<td>SERVICE FACILITY LOCATION INFORMATION</td>
</tr>
<tr>
<td>33.</td>
<td>BILLING PROVIDER INFO &amp; PH #</td>
</tr>
<tr>
<td>34.</td>
<td>CH.295</td>
</tr>
<tr>
<td>35.</td>
<td>CH-21 Diagnosis and Treatment (Referral from THSteps Checkup)</td>
</tr>
</tbody>
</table>

**NUCC Instruction Manual available at: www.nucc.org**
1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CH.22 Durable Medical Equipment (CCP Only)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.
**CH.23 Early Childhood Intervention Specialized Skills Training (SST)**

---

### HEALTH INSURANCE CLAIM FORM

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

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE</th>
<th>CHAMPUS</th>
<th>CHAMPVA</th>
<th>GROUP HEALTH PLAN</th>
<th>FECA</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare #</td>
<td>Medicaid #</td>
<td>(Sponsor's SSN)</td>
<td>(Member ID)</td>
<td>(SSN or ID)</td>
<td>(SSN or ID)</td>
<td>(SSN)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. PATIENT’S NAME</th>
<th>(Last Name, First Name, Middle Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doe, Jane B.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. PATIENT’S BIRTH DATE</th>
<th>MM</th>
<th>DD</th>
<th>YY</th>
</tr>
</thead>
<tbody>
<tr>
<td>03</td>
<td>24</td>
<td>2011</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. INSURED’S NAME</th>
<th>(Last Name, First Name, Middle Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. PATIENT’S ADDRESS</th>
<th>(No., Street)</th>
</tr>
</thead>
<tbody>
<tr>
<td>632 Baker Lane</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. CITY</th>
<th>STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin</td>
<td>TX</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. PATIENT’S SIGNATURE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>8. PATIENT STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. OTHER INSURED’S NAME</th>
<th>(Last Name, First Name, Middle Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. PATIENT’S ADDRESS</th>
<th>(No., Street)</th>
</tr>
</thead>
<tbody>
<tr>
<td>110 N. Austin Blvd</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. CITY</th>
<th>STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin</td>
<td>TX</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. PATIENT’S SIGNATURE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>13. PATIENT’S SIGNATURE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>14. DATE OF CURRENT ILLNESS (First symptom) OR ILLNESS (First symptom)</th>
<th>MM</th>
<th>DD</th>
<th>YY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>03</td>
<td>24</td>
<td>2011</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</th>
<th>MM</th>
<th>DD</th>
<th>YY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>03</td>
<td>24</td>
<td>2011</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16. PATIENT’S ADDRESS</th>
<th>(No., Street)</th>
</tr>
</thead>
<tbody>
<tr>
<td>632 Baker Lane</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doe, Jane B.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18. PATIENT’S SIGNATURE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>19. RESERVED FOR LOCAL USE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>20. PATIENT’S SIGNATURE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relates 1, 2, 3 or 4 to Item 24E by Line)</th>
</tr>
</thead>
<tbody>
<tr>
<td>783 41</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>22. MEDICAID RESUBMISSION CODE</th>
<th>ORIGINAL REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 23. PRIOR AUTHORIZATION NUMBER | |
|-------------------------------| |

---

**NUCC Instruction Manual available at:** www.nucc.org

---
### CH.24 Early Childhood Intervention Targeted Case Management with Face-to-Face Interaction

#### HEALTH INSURANCE CLAIM FORM

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Insured's Name:** Doe, Jane A.
- **Address:** 632 Baker Lane
- **City:** Austin
- **State:** TX
- **ZIP Code:** 78757
- **Telephone:** (512) 555-1234

#### Signature on File

- **Signed:** Julie Brown
- **Signed Date:** 02 05 2013

#### Date of Current Illness/Injury

- **Date:** 03 24 2011
- **Sex:** M

#### Diagnosis or Nature of Illness or Injury

- **Diagnosis:** Early Childhood Developmental Delay

#### Other Insured's Information

- **Name:** Doe, Jane A.
- **Policy or Group Number:** 1234567-01
- **SSN:** 9876543021

#### Patient Information

- **Name:** Doe, Jane A.
- **Policy or Group Number:** 1234567-01
- **SSN:** 9876543021

#### Provider Information

- **NPI:** 123456789
- **Physician or Supplier:** Early Childhood Developmental Disabilities Clinic
- **Address:** 123 Springdale Drive
- **City:** Austin
- **State:** TX
- **ZIP Code:** 78759

#### Other Information

- **Billing Provider:** (512) 555-1234
- **Insurance:** Medicaid
- **Service:** Face-to-Face Intervention

---

**Note:** This form and information are approved by the National Uniform Claim Committee (08/05) and are subject to change. For more details, please refer to the latest version of the Texas Medicaid Provider Procedures Manual. © 2012 American Medical Association. All rights reserved.
### CH.26 Inpatient Rehabilitation Facility (Freestanding) (CCP Only)

**Rehabilitation Hospital**
999 West Blvd.  
Tyler, TX 75702  
903-555-1234

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Doe, Jane</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>4312 Branbury Cross, Tyler, TX 75702</td>
</tr>
</tbody>
</table>

**Date of Birth** 04/03/2001  
**Sex** F  
**SSN** 01/01/2013  
**Medical Record Number** 34210

**Insurance Information**
- **Insured** Doe, Jane  
- **Group Name** 123456789  
- **NPI** 123456789

**Certifications**
The certifications on the reverse apply to this bill and are made a part hereof.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Date</th>
<th>Code</th>
<th>Value Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>128</td>
<td>Semi Private Room</td>
<td>01/01/2013</td>
<td>400.00</td>
<td>Room 400.00</td>
<td>14</td>
</tr>
<tr>
<td>250</td>
<td>Pharmacy</td>
<td>01/01/2013</td>
<td>Rate</td>
<td>298.63</td>
<td></td>
</tr>
<tr>
<td>270</td>
<td>Medical/Surgical Supplies</td>
<td>01/01/2013</td>
<td>542.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>300</td>
<td>Laboratory</td>
<td>01/01/2013</td>
<td>210.28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>420</td>
<td>Physical Therapy</td>
<td>01/01/2013</td>
<td>4878.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>430</td>
<td>Occupational Therapy</td>
<td>01/01/2013</td>
<td>6878.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>910</td>
<td>Psychiatric Services - General</td>
<td>01/01/2013</td>
<td>1794.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Charges** 20201.07

**Medical Services**
- **Primary Procedure** Hemiplegia, Spastic
- **Other Procedures**

**Bill Information**
- **UB-04 Code** 34210  
- **Creation Date** 01/01/2013  
- **Bill Number** 123456789

**Certifications**
The certifications on the reverse apply to this bill and are made a part hereof.
### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/05**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>MEDICARE</strong></td>
<td>Medicare #</td>
</tr>
<tr>
<td>2. <strong>PATIENT’S NAME</strong></td>
<td>Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>3. <strong>PATIENT’S BIRTH DATE</strong></td>
<td>10 26 2007</td>
</tr>
<tr>
<td>4. <strong>INSURED’S NAME</strong></td>
<td>Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>5. <strong>PATIENT’S ADDRESS</strong></td>
<td>(No., Street)</td>
</tr>
<tr>
<td>6. <strong>PATIENT’S STATUS</strong></td>
<td>Single</td>
</tr>
<tr>
<td>7. <strong>INSURED’S ADDRESS</strong></td>
<td>(No., Street)</td>
</tr>
<tr>
<td>8. <strong>PATIENT’S SIGNATURE</strong></td>
<td>Signature on File</td>
</tr>
<tr>
<td>9. <strong>INSURED’S SIGNATURE</strong></td>
<td>Signature on File</td>
</tr>
<tr>
<td>10. <strong>INSURED’S DATE OF BIRTH</strong></td>
<td>MM DD YY</td>
</tr>
<tr>
<td>11. <strong>INSURED’S POLICY GROUP OR FECA NUMBER</strong></td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>12. <strong>PATIENT’S DATE OF BIRTH</strong></td>
<td>MM DD YY</td>
</tr>
<tr>
<td>13. <strong>INSURED’S I.D. NUMBER</strong></td>
<td>(For Program in Item 1)</td>
</tr>
<tr>
<td>14. <strong>DATE(S) OF SERVICE</strong></td>
<td>From DD MM YYYY To DD MM YYYY</td>
</tr>
<tr>
<td>15. <strong>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</strong></td>
<td>Relate Items 1, 2, 3 or 4 to Item 14E by Line</td>
</tr>
<tr>
<td>16. <strong>OUTSIDE LAB? $ CHARGES</strong></td>
<td>YES</td>
</tr>
<tr>
<td>17. <strong>NAME OF REFERRING PROVIDER OR OTHER SOURCE</strong></td>
<td>Smith, Jane, M.D.</td>
</tr>
<tr>
<td>18. <strong>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</strong></td>
<td>Relate Items 1, 2, 3 or 4 to Item 14E by Line</td>
</tr>
<tr>
<td>19. <strong>RESERVED FOR LOCAL USE</strong></td>
<td>YES</td>
</tr>
<tr>
<td>20. <strong>INSURED’S ACCOUNT NO.</strong></td>
<td></td>
</tr>
<tr>
<td>21. <strong>BILLING PROVIDER INFO &amp; PH #</strong></td>
<td>Jill Brown, 101 Main Street, Austin, TX 78728</td>
</tr>
<tr>
<td>22. <strong>PRIOR AUTHORIZATION NUMBER</strong></td>
<td></td>
</tr>
</tbody>
</table>

**CPT-Only - Copyright 2012 American Medical Association. All Rights Reserved.**
# CH.28 Occupational Therapists (CCP Only)

## HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 88/05**

**PICA: CH-302**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>85502-85508</td>
<td>Occupational Therapy Services, including consultation and evaluation services.</td>
</tr>
</tbody>
</table>

### Patient Information

- **Name:** Colin K. Smith, OT
- **Address:** 1234 Glen Drive, Webster, TX 78801
- **SSN:** 1234567-01
- **Date of Birth:** 02 10 2013

### Physician Information

- **Name:** Phyllis Merrick, M.D.
- **SSN:** 03 27 1994
- **Office Address:** 1234 Glen Drive, Webster, TX 78801
- **Telephone:** 210 555-1234

### Procedure Information

- **Procedure Code:** 85502-85508
- **Units:** 1
- **Place of Service:** Office

### Bill Information

- **Provider ID:** 1234567890
- **Physician Provider ID:** NPI

---

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

- **Carrying:** NPI
- **Physician:** NPI

---

**CHAMPUS/FECA CLAIMS**

- **Billing Provider Info & PH #:** Colin K. Smith, OT 1234567-01
- **Address:** 406 Kings Hwy, Webster, TX 78801

---

**NCCI Instruction Manual available at:** www.nucc.org

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

---

**CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.**
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CPT/HCPCS MODIFIER

1. MEDICARE      MEDICAID      TRICARE
      CHAMPUS (Sponsor's SSN)    CHAMPVA
      (Medicare #)   (Medicaid #)  (Sponsor's SSN)
      MEDICAID   TRICARE   CHAMPUS
      (Medicare #)   (Medicaid #)  (Sponsor's SSN)

1A. HEALTH PLAN
      GROUP (SSN or ID)  FECA (SSN or ID)

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

3. PATIENT'S BIRTH DATE
     11/23/1994
     M  F

5. PATIENT'S ADDRESS (No., Street)
     563 Lake Ct.

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

8. PATIENT'S BIRTH DATE
     11/23/1994
     M  F

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

10. IS PATIENT'S CONDITION RELATED TO:
     Yes  No

11. INSURED'S POLICY GROUP OR FECA NUMBER

14. INSURED'S I.D. NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF RefERRING PROVIDER OR OTHER SOURCE
     Joanne Wallace, M.D.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

22. MEDICAID RESUBMISSION

23. PRIOR AUTHORIZATION NUMBER

24. DATE(S) OF SERVICE

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT
     Yes  No

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

SIGNATURE on FILE

SIGNED DATE

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

NUCC Instruction Manual available at: www.nucc.org

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 1. 2. 3.

3. PATIENT'S BIRTH DATE MM DD YY 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 1. 2. 3.

4. SEX M  X

5. PATIENT'S ADDRESS (No., Street) 1200 Baltic

6. PATIENT RELATIONSHIP TO INSURED
   Spouse  Child  Other

7. INSURED'S ADDRESS (No., Street) 1200 Baltic

8. PATIENT'S BIRTH DATE MM DD YY

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 1. 2. 3.

10. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the undersigned physician or supplier for services described below.

11. INSURED'S POLICY GROUP OR FECA NUMBER 1. 2. 3.

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

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

14. DATE OF CURRENT OCCUPATION

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES

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

22. MEDICARE RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM TO

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SERVICE FACILITY LOCATION INFORMATION

32. BILLING PROVIDER INFO & PH #

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

NUCC Instruction Manual available at www.nucc.org
# CH.31  Private Duty Nurses (CCP Only)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>Date</th>
<th>Occurrence</th>
<th>Occurrence</th>
<th>Occurrence</th>
<th>Occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Services LVN/RN, private duty nursing per hour</td>
<td>T1002</td>
<td>01212013</td>
<td>5</td>
<td>200 00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Charges**: 200 00

---

**Notes**: The certifications on the reverse apply to this bill and are made a part hereof.
1500 HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE医用
MEDICAID
TRICARE
CHAMPVA
CHAMPUS
(Plan Sponsor's SSN)
3. BILLING PROVIDER INFO & PH #
PHYSICIAN OR SUPPLIER INFORMATION
4. MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2 - DECEMBER 2013
5. BILLING PROVIDER INFO & PH #
PHYSICIAN OR SUPPLIER INFORMATION

PICA
CH-306

CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Medicare</td>
</tr>
<tr>
<td>2.</td>
<td>Patient’s Name (Last, First, Middle Initial)</td>
</tr>
<tr>
<td>3.</td>
<td>Patient’s Birth Date</td>
</tr>
<tr>
<td>4.</td>
<td>Insured’s Name (Last, First, Middle Initial)</td>
</tr>
<tr>
<td>5.</td>
<td>Patient’s Address (No., Street)</td>
</tr>
<tr>
<td>6.</td>
<td>Patient Relationship to Insured</td>
</tr>
<tr>
<td>7.</td>
<td>Insured’s Address (No., Street)</td>
</tr>
<tr>
<td>8.</td>
<td>Patient Status</td>
</tr>
<tr>
<td>9.</td>
<td>Other Insured’s Name (Last, First, Middle Initial)</td>
</tr>
<tr>
<td>10.</td>
<td>Insured’s Date of Birth</td>
</tr>
<tr>
<td>11.</td>
<td>Insured’s Policy or FECA Number</td>
</tr>
<tr>
<td>12.</td>
<td>Insured’s I.D. Number</td>
</tr>
<tr>
<td>13.</td>
<td>Insured’s Policy Group or FECA Number</td>
</tr>
<tr>
<td>14.</td>
<td>Insured’s Signature</td>
</tr>
<tr>
<td>15.</td>
<td>Insurer’s Signature</td>
</tr>
<tr>
<td>16.</td>
<td>Authorizing Signature</td>
</tr>
<tr>
<td>17.</td>
<td>Name of Referring Provider</td>
</tr>
<tr>
<td>18.</td>
<td>Hospitalization Dates Related to Current Services</td>
</tr>
<tr>
<td>19.</td>
<td>Place of Service</td>
</tr>
<tr>
<td>20.</td>
<td>Outside Lab?</td>
</tr>
<tr>
<td>21.</td>
<td>Diagnosis or Nature of Illness or Injury</td>
</tr>
<tr>
<td>22.</td>
<td>Medicares Resubmission Code</td>
</tr>
<tr>
<td>23.</td>
<td>Prior Authorization Number</td>
</tr>
<tr>
<td>24.</td>
<td>Date(s) of Service</td>
</tr>
<tr>
<td>25.</td>
<td>Federal Tax I.D. Number</td>
</tr>
<tr>
<td>26.</td>
<td>Patient’s Account No.</td>
</tr>
<tr>
<td>27.</td>
<td>Accept Assignment?</td>
</tr>
<tr>
<td>28.</td>
<td>Total Charge</td>
</tr>
<tr>
<td>29.</td>
<td>Amount Paid</td>
</tr>
<tr>
<td>30.</td>
<td>Balance Due</td>
</tr>
<tr>
<td>31.</td>
<td>Signature of Physician or Supplier including Degrees or Credentials</td>
</tr>
<tr>
<td>32.</td>
<td>Service Facility Location Information</td>
</tr>
<tr>
<td>33.</td>
<td>Billing Provider Info &amp; PH #</td>
</tr>
</tbody>
</table>

NR: Not Required
**HEALTH INSURANCE CLAIM FORM**

**MEDICAID OF TX**

PO BOX 200555
AUSTIN, TX 78720-0555

---

**1. MEDICARE**
**2. MEDICAID**
**3. TRICARE**
**4. CHAMPUS**
**5. CHAMPVA**
**6. GROUP HEALTH PLAN (SSN or ID)**
**7. FECA (SSN or ID)**
**8. OTHER (SSN or ID)**

**9. PATIENT'S NAME (Last Name, First Name, Middle Name)**
Doe, Jane

**10. PATIENT'S BIRTH DATE**
03 15 2005

**11. PATIENT'S ADDRESS (No., Street)**
5432 West Main St.

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

**13. INSURED'S SIGNATURE**
I authorize the release of any medical or other information necessary to process this claim.

---

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

**16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**

---

**19. RESERVED FOR LOCAL USE**

---

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

---

**24. A. DATES(S) OF SERVICE**

<table>
<thead>
<tr>
<th>MM DD YY</th>
<th>MM DD YY</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 05 2013</td>
<td>01 05 2013</td>
</tr>
</tbody>
</table>

**B. CODE(S) OF SERVICE**

<table>
<thead>
<tr>
<th>CPT/HCPCS MODIFIER</th>
<th>PROFESSIONAL UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>99383</td>
<td></td>
</tr>
</tbody>
</table>

**C. BILLING PROVIDER INFORMATION**

**D. MEDICAID RESUBMISSION**

**E. PRIOR AUTHORIZATION NUMBER**

---

**26. FEDERAL I.D. NUMBER**

**27. PATIENT'S ACCOUNT NO**

**28. TOTAL CHARGE**

**29. AMOUNT PAID**

**30. BALANCE DUE**

---

**31. SIGNATURE OF PHYSICIAN OR SUPPLIER**

**32. SERVICE FACILITY LOCATION INFORMATION**

---

**SIGNATURE ON FILE**

---

**NUCC Instruction Manual available at:** www.nucc.org

---

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

**MEDICAID OF TX**

PO BOX 200555
AUSTIN, TX 78720-0555

**CITY**

**STATE**

**ZIP CODE**

**TELEPHONE (Include Area Code)**

**Lubbock**

**TX**

**79488**

**Employed**

**Full-Time**

**Part-Time**

**Student**

**Other**

**SEX**

**MM** **DD** **YY**

**M**

**F**

**YES**

**NO**

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

**CH.35 THSteps Established Patient Exception to Periodicity and Referral, Immunizations with Counseling, and by a Physician**

**NUCC Instruction Manual available at: www.nucc.org**

**CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.**
CH.36  THSteps Established Patient and Referral, Tuberculin Skin Test (TST), and Physical Examination by a Physician
APPENDIX A: THSteps FORMS

A.1 Claim Forms ................................................................. CH-312
A.2 THSteps Medical Checkup Forms ............................................ CH-312
A.3 Laboratory Forms ............................................................. CH-313
A.4 Guidelines for Tuberculosis Skin Testing ................................. CH-313
A.5 Tuberculosis Screening and Guidelines ..................................... CH-313
CH.37 How to Determine TB Risk ............................................. CH-315
A.6 Texas Vaccines For Children (TVFC) ........................................ CH-316
CH.38 TVFC Patient Eligibility Screening Record ............................... CH-316
CH.39 TVFC Patient Eligibility Screening Record (Spanish) ................. CH-317
CH.40 TVFC Provider Enrollment (3 Pages) ..................................... CH-318
CH.41 TVFC Questions and Answers (3 Pages) ................................. CH-321
A.1 Claim Forms
Providers must order CMS-1500 and American Dental Association (ADA) Dental Claims Forms from the vendor of their choice. Copies cannot be used. Claims filing instructions and examples of the claim forms are located in Section 6: Claims Filing (Vol. 1, General Information).


A.2 THSteps Medical Checkup Forms
The use of the child health clinical records is optional. These forms were developed to help providers document all components of the medical checkup. Unless required to be submitted to another program, one of the following forms of documentation must be included in the client’s medical record: The completed screening tools with results, the completed questions to the tools within a provider-created medical record, and the results of the completed screening tools. Providers may be asked to provide the screening tool used to complete the screening. Texas Health Steps (THSteps) requires the following forms: Tuberculosis (TB) Questionnaire and the Texas Department of State Health Services (DSHS) State Laboratory forms. These forms can be downloaded from the THSteps website at www.dshs.state.tx.us/thsteps/forms.shtm. The Parent Hearing Checklist and Lead Risk Questionnaire are optional forms. Lead poisoning screening questionnaires can be downloaded from the Texas Childhood Lead Poisoning Prevention Program (TX CLPPP) website at www.dshs.state.tx.us/lead/providers.shtm.

Links to growth charts may be found on the THSteps website at www.dshs.state.tx.us/thsteps/forms.shtm.

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Form Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECH-1</td>
<td>Child Health History Form</td>
</tr>
<tr>
<td>ECHR-5 Day</td>
<td>Discharge to 5 day Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-2 Week</td>
<td>2 Week Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-2 Month</td>
<td>2 Month Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-4 Month</td>
<td>4 Month Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-6 Month</td>
<td>6 Month Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-9 Month</td>
<td>9 Month Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-12 Month</td>
<td>12 Month Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-15 Month</td>
<td>15 Month Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-18 Month</td>
<td>18 Month Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-24 Month</td>
<td>24 Month Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-30 Month</td>
<td>30 Month Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-3 Year</td>
<td>3 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-4 Year</td>
<td>4 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-5 Year</td>
<td>5 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-6 Year</td>
<td>6 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-7 Year</td>
<td>7 Year Visit Child Health Record</td>
</tr>
</tbody>
</table>
Providers should refer to sources such as *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (2nd edition, revised), located at www.brightfutures.org or the Guidelines for Adolescent Preventive Services (GAP) Implementation Materials located at http://aappolicy.aappublications.org/cgi/content/full/pediatrics;121/6/1263. For nutritional screening for all ages, refer to Bright Futures.

### A.3 Laboratory Forms

For information on procedures for submission of laboratory forms, refer to the DSHS Laboratory Services Section’s web page at www.dshs.state.tx.us/lab/MRS_forms.shtm.

### A.4 Guidelines for Tuberculosis Skin Testing

For information on procedures for tuberculosis skin testing, refer to the DSHS tuberculosis web page at www.dshs.state.tx.us/idcu/disease/tb/.

### A.5 Tuberculosis Screening and Guidelines

The screening tool for tuberculosis (TB) exposure risk is to be used annually to determine the need for tuberculin skin testing.

The questions in the screening tool are intended as a minimum screen. Follow-up questions may be necessary to clarify hesitant or ambiguous responses. Questions specific to TB exposure risks in the client’s community may need to be added.

The following applies for tuberculin screening and skin testing:

- If all the answers are unqualified negatives, the client is considered at low risk for exposure to TB and will not need tuberculin skin testing.
- If the answer to any question is “Yes” or “I don’t know,” the client should be tuberculin skin tested.
- In the case of the client for whom an answer in the past of “Yes” or “I don’t know” prompted a skin test, which was negative, the skin test may not have to be repeated annually.

---

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Form Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECHR-8 Year</td>
<td>8 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-9 Year</td>
<td>9 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-10 Year</td>
<td>10 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-11 Year</td>
<td>11 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-12 Year</td>
<td>12 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-13 Year</td>
<td>13 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-14 Year</td>
<td>14 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-15 Year</td>
<td>15 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-16 Year</td>
<td>16 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-17 Year</td>
<td>17 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-18 Year</td>
<td>18 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-19 Year</td>
<td>19 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-20 Year</td>
<td>20 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-19-20 Year</td>
<td>19 &amp; 20 Year Visit Child Health Record</td>
</tr>
<tr>
<td>Form Pb-110, Lead Risk Questionnaire</td>
<td>Form Pb-110, Lead Risk Questionnaire</td>
</tr>
</tbody>
</table>
• The decision to administer a skin test must be made by the medical provider based upon an assessment of the possibility of exposure. A negative tuberculin skin test never excludes tuberculosis infection or active disease.

• Bacillus of Calmette and Guérin (BCG) vaccinated clients should also have the screening tool administered annually. Previous BCG vaccination is not a contraindication to tuberculin skin testing. Positive tuberculin skin tests in BCG vaccinated children are interpreted using the same guidelines used for non-BCG vaccinated children.

• Clients who have had a positive TB skin test in the past (whether treated or not), should be re-evaluated at least annually by a physician for signs and symptoms of TB.

Care of clients who are newly discovered to be tuberculin skin test positive includes:

• An evaluation for signs and symptoms of TB.

• A chest X-ray to rule out active disease.

• Oral medications to prevent progression to active disease or multi-drug therapy if active disease is present.

• Referral for consultation by a pediatric TB specialist is recommended if active disease is present.

• A report to the local health authority for investigation to find the source of the infection.

The TB screening tool is available on the THSteps website at www.dshs.state.tx.us/thsteps/forms.shtm.
CH.37  How to Determine TB Risk

Risk of potential tuberculosis exposure as revealed by questionnaire

YES

Past TB skin test

YES

No skin test

NO

NO skin test

SKIN TEST

NO

NO skin test

YES

Have risk occurred since last negative skin test

(+)* Positive

(-)* Negative

NO

NO further action

CLINICAL EXAM*

YES

Symptoms of TB disease

NO

Clinical exam*

NO

Therapy completed

YES

No further action

NO

No further action

* Clinical exam includes:
  medical/social history
  physician exam
  chest x-ray
  Consult physician/TB health experts about need for:
  bacteriology
  treatment
A.6 Texas Vaccines For Children (TVFC)

CH.38  TVFC Patient Eligibility Screening Record

This same record will satisfy the requirements for all subsequent vaccinations, as long as the child’s eligibility has not changed. If patient eligibility changes, a new form must be completed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

Date of Screening: ________________

Child’s Name: ____________________________________________

Parent/Guardian/Individual of Record:

Last Name         First Name        MI

Please check the first category that applies; check only one.

(a)  □ Is enrolled in Medicaid, or

Medicaid Number: ____________________________ Date of Eligibility (mm/dd/yyyy)

(b)  □ Is an American Indian, or

(c)  □ Is an Alaskan Native, or

(d)  □ Does not have health insurance (uninsured), or

(e)  □ Is a patient who receives benefits from the Children’s Health Insurance Plan (CHIP) and is being seen at a facility that bills CHIP, or

CHIP Number: ____________________________ Date of Eligibility (mm/dd/yyyy)

(f)  □ Is underinsured:

□  1) has commercial (private) health insurance, but coverage does not include vaccines; or

□  2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or

□  3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

(g)  □ Has private insurance that covers vaccines:

Name of Insurer: ____________________________ Insurer Contact Number: ____________________________

Policy/Subscriber Number: ____________________________ Group Number (if applicable): ____________________________

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is an authorized person and is eligible to receive TVFC vaccines.

Signature: ____________________________ Date: ________________

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Clinic Use Only

I certify any services for CHIP members will be billed to CHIP: □ Yes □ No

TVFC Eligible: □ Yes □ No

Screener’s Initials: ____________
**CHILDREN'S SERVICES HANDBOOK**

**CH.39 TVFC Patient Eligibility Screening Record (Spanish)**

**PROGRAMA DE VACUNAS PARA NIÑOS DE TEXAS (o TVFC)
REGISTRO DE DETERMINACIÓN DEL DERECHO A LA PARTICIPACIÓN DEL PACIENTE**

Debe mantenerse un registro de todos los niños de 18 años de edad o menos que reciban inmunizaciones por medio del Programa de Vacunas para Niños de Texas en el consultorio de un proveedor de salud. Dicho registro lo puede llenar el padre o la madre, el tutor, el individuo cuyo nombre consta en el registro o el proveedor de salud. En cada visita de inmunización deben asegurarse de que el niño siga teniendo derecho a participar en el TVFC. Este mismo registro satisfará los requisitos para todas las vacunaciones posteriores, en tanto el niño siga teniendo derecho a participar. Si cambia el derecho a la participación del paciente, debe rellenarse un nuevo formulario. Aunque no se requiere verificar las respuestas, es necesario conservar este registro, o uno similar, por cada niño que reciba vacunas bajo el Programa de TVFC.

Fecha de la determinación: __________________ (mm/dd/aaaa)

Nombre del niño:

Apellido                Primer nombre                   Inicial del 2.o nombre

Fecha de nacimiento del niño: __________________ (mm/dd/aaaa)  Edad: ______

Padre o madre, tutor o individuo cuyo nombre consta en el registro:

Apellido    Primer nombre      Inicial del 2.o nombre

Marque la primera categoría que corresponda; marque sólo una.

(a)  □ Está inscrito en Medicaid, o

(b)  □ Es indio americano, o

(c)  □ Es nativo de Alaska, o

(d)  □ No tiene seguro médico (no está asegurado), o

(e)  □ Es un paciente y recibe prestaciones del Plan de Seguro Médico Infantil (o CHIP) y lo están atendiendo en un complejo que cobra al CHIP, o

(f)  □ Está subasegurado:

   1)   Tiene seguro médico comercial (privado), pero la cobertura no incluye las vacunas; o

   2)   El seguro sólo cubre ciertas vacunas (reúne los requisitos del TVFC sólo para las vacunas no cubiertas); o

   3)   El seguro limita la cobertura de vacunas a cierta cantidad. Una vez alcanzada dicha cantidad cubierta, se categorizará al niño como subasegurado.

(g)  □ Tiene seguro privado que cubre las vacunas:

   Nombre del asegurador: __________________   Número de contacto del asegurador: (______)

   Código de área y el número

   Número de póliza/asegurado: __________________   Número del grupo (si es aplicable): __________________

NOTA: El que falsoifique a sabiendas la información en este documento constituye un fraude. Al firmar el formulario, doy fe de que la información de arriba es verídica y correcta. Declaro que la persona antes mencionada es la persona autorizada y reúne los requisitos para recibir vacunas por medio del TVFC.

Firma: __________________   Fecha: __________________ (mm/dd/aaaa)

Con ciertas excepciones, tiene derecho a pedir y a ser informado sobre la información que el estado de Texas reúne sobre usted. Tiene derecho a recibir y examinar la información al pedirla. También tiene derecho a pedir a la agencia estatal que corrija cualquier información que se determine es incorrecta. Consulte http://www.dshs.state.tx.us para obtener más información sobre la notificación de privacidad. (Referencia: Código gubernamental, sección 552.021, 552.023, 559.003 y 559.004)

Sólo para uso de la clínica (Clinic Use Only)

I certify any services for CHIP members will be billed to CHIP:  □ Yes   □ No

TVFC Eligible:  □ Yes   □ No

Screener’s Initials: __________________

Texas Department of State Health Services
Immunization Branch

Stock No. C-10
Revised 11/2012

CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.
**Texas Department of State Health Services**

Immunization Branch

Texas Department of State Health Services

Immunization Branch

Stock Number E6-102

Page 1

Revised 02/2012

---

**CH.40 TVFC Provider Enrollment (3 Pages)**

---

**TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC): PROVIDER ENROLLMENT**

- Initial enrollment*
- Re-enrollment
- Provider PIN Number __ __ __ __ __ __

(*Contact the Health Services Region [HSR] in your area to obtain PIN) Responsible Entity __________________________

---

Name of Facility, Practice, or Clinic: __________________________

Provider Name (M.D., D.O., N.P., R.Ph., P.A., or C.N.M.)*:

- (Last Name) __ __ __ __ __ __
- (First Name) __ __ __ __ __ __
- (MI) __ __ __ __ __ __
- (Title) __ __ __ __ __ __

Contact: __________________________

- (Last Name) __ __ __ __ __ __
- (First Name) __ __ __ __ __ __
- (MI) __ __ __ __ __ __
- (Title) __ __ __ __ __ __

Mailing Address:

- (P.O. Box or Street Address) __________________________
- (City) __________________________
- (Zip) __________________________

Address for Vaccine Delivery:

- (Street Address and Suite Number) __________________________
- (City) __________________________
- (County) __________________________
- (Zip) __________________________

Telephone Number: (________)________-__________

Fax Number: (________)________-__________

E-mail Address: __________________________

---

In order to participate in the Texas Vaccines for Children Program and/or to receive federally- and state-supplied vaccines provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization, agree to the following:

1) This office/facility will screen patients for TVFC eligibility at all immunization encounters, and administer TVFC-purchased vaccine only to children 18 years of age or younger who meet one or more of the following criteria: (1) Is an American Indian or Alaska Native; (2) is enrolled in Medicaid; (3) has no health insurance; (4) is uninsured: children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only), children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as uninsured); (5) is a patient who receives benefits from the Children’s Health Insurance Plan (CHIP).

2) This office/facility will maintain all records related to the TVFC program, including parent/guardian/authorized representative’s responses on the Patient Eligibility Screening Form for at least five years. If requested, this office/facility will make such records available to the Texas Department of State Health Services (DSHS), the local health department/authority, or the U.S. Department of Health and Human Services.

3) This office/facility will comply with the appropriate vaccination schedule, dosage, and contraindications, as established by the Advisory Committee on Immunization Practices, unless (a) in making a medical judgment in accordance with accepted medical practice, this office/facility deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas Law, including laws relating to religious and medical exemptions.

4) This office/facility will provide Vaccine Information Statements (VIS) to the responsible adult, parent, or guardian and maintain records in accordance with the National Childhood Vaccine Injury Act which include reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS). Signatures are required for informed consent. (The Texas Addendum portion of the VIS may be used to document informed consent.)

5) This office/facility will not charge for vaccines supplied by DSHS and administered to a child who is eligible for the TVFC.

6) This office/facility may charge a vaccine administration fee to non-Medicaid or non-CHIP TVFC eligible patients not to exceed $14.85. Medicaid patients cannot be charged for the vaccine, administration of vaccine, or an office visit associated with Medicaid services. For Medicaid patients, this office/facility agrees to accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.

7) This office/facility will not deny administration of a TVFC vaccine to a child because of the inability of the child’s parent or guardian/individual of record to pay an administrative fee.

8) This office/facility will comply with the State’s requirements for ordering vaccine and other requirements as described by DSHS, and operate within the TVFC program in a manner intended to avoid fraud and abuse.

9) This office/facility or the State may terminate this agreement at any time for failure to comply with these requirements. If the agreement is terminated for any reason this office/facility agrees to properly return any unused vaccine.

10) This office/facility will allow DSHS (or its contractors) to conduct on-site visits as required by VFC regulations.

---

(Signature*) __________________________

(Date) __________________________

(Print Name and Title) __________________________

---

* A licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant, Registered Pharmacist, or a Certified Nurse Midwife must sign the TVFC Enrollment Form.
### TEXAS VACCINES FOR CHILDREN PROGRAM

**PROVIDER PROFILE FOR PIN _______ _______ _______ _______ _______**

Is your facility a: (✓ check one)
- Federally Qualified Health Center
- Migrant Health Clinic
- Rural Health Clinic
- None of these

(Provider must meet the federal requirements established for FQHC or RHC programs.)

Type of Clinic: (✓ check one)
- Public Health Department/District
- Private Hospital
- Pharmacy
- Public Hospital
- Private Practice (Individual or Group)
- Other Public Clinic
- Other Private Clinic

**PATIENT PROFILE:**

Please enter the number of children for each of the following categories and by age group who will be vaccinated at your clinic in the next 12-month period.

<table>
<thead>
<tr>
<th>NUMBER OF CHILDREN IN EACH CATEGORY</th>
<th>&lt; 1 year old</th>
<th>1 - 6 years</th>
<th>7 - 18 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled in Medicaid.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured. (Note: Children enrolled in Health Maintenance Organizations are considered insured)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indians.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaskan Natives.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underinsured: children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only), children whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, these children are categorized as underinsured.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children who receive benefits from the Children’s Health Insurance Plan (CHIP).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children who are vaccinated in your practice, but are NOT TVFC-eligible.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL PATIENTS:** (Add columns)

---

**TEXAS VACCINES FOR CHILDREN PROGRAM PROVIDER LIST**

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Title (MD, DO, NP, RPh, PA, RN, LVN, MA)</th>
<th>National Provider Identification</th>
<th>Medical License Number</th>
<th>Specialty (Family Medicine, Pediatrics, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# TEXAS VACCINES FOR CHILDREN PROGRAM

PROVIDER LIST-ADDENDUM FOR PIN ___ ___ ___ ___ ___ ___

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Title (MD, DO, NP, RPh, PA, RN, LVN, MA)</th>
<th>National Provider Identification</th>
<th>Medical License Number</th>
<th>Specialty (Family Medicine, Pediatrics, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Questions and Answers

Texas Vaccines For Children Program (TVFC)

Question 1: What is the TVFC?

Answer: This is our version of the Federal Vaccines For Children (VFC) Program. The TVFC was initiated by the passage of the Omnibus Budget Reconciliation Act of 1993. This legislation guaranteed vaccines would be available at no cost to providers, in order to immunize children (birth - 18 years of age) who meet the eligibility requirements.

Why Enroll?

Question 2: Why should a health care provider enroll in the TVFC?

Answer: • You can get free vaccine for your eligible patients.
• You will not need to refer patients to public clinics for vaccines.
• You can provide vaccinations to your patients as part of a comprehensive care package; this will enhance the opportunity for patients to find a medical home.

Patients Served

Question 3: Once enrolled, are providers required to immunize children who are not their patients?

Answer: No, you control whom you see in your practice.

Children Who Qualify

Question 4: Which children qualify for free vaccines?

Answer: All children (birth - 18 years of age) are eligible for free vaccine, except:
• Children with insurance that pays for immunization services, and
• Children whose parents or guardians are able to pay the co-pay or deductibles for immunization services.
Questions and Answers

Children’s Health Insurance Program (CHIP) Enrollment

Question 5: Are children who are enrolled in CHIP eligible?
Answer: Yes, through special arrangement CHIP children are also eligible.

Medicaid Enrollment

Question 6: To participate in TVFC, must providers enroll as a Texas Medicaid Provider?
Answer: No, however, if you are enrolled in the Texas Medicaid Program, you must enroll in TVFC in order to receive free vaccine.

Question 7: Will the Texas Medicaid Program reimburse private providers for vaccines administered to Medicaid patients?
Answer: The Texas Medicaid Program will not reimburse providers for the cost of the vaccine. However, the Texas Medicaid Program will reimburse providers for the administration of the vaccine.

Vaccine Related Fees

Question 8: Why are there fee caps on what providers can charge for administering vaccine?
Answer: Federal Legislation requires fee caps for administration on a statewide basis that balance the provider’s financial need and the patient’s ability to pay.

Question 9: Will TVFC reimburse an administration fee for non-Medicaid, TVFC eligible children?
Answer: No, for non-Medicaid TVFC eligible children, providers may charge a maximum of $14.85 per vaccine directly to the patient; administration fees may not exceed this amount. (Combination vaccines such as DTaP are considered one vaccine.)
Questions and Answers

Question 10: Will providers be required to increase the amount of vaccine information materials they provide to parents because of the TVFC?

Answer: No, materials required of all providers through the National Childhood Vaccine Injury Act are sufficient.

Eligibility Status

Question 11: Must providers screen patients for eligibility status each time they come for a vaccination visit?

Answer: Yes, providers must screen patients for eligibility status each time they come for a vaccination visit. However, a new eligibility form does not need to be completed unless the patient’s eligibility status has changed.

Question 12: How are providers expected to verify responses for TVFC eligibility?

Answer: Providers are not expected to do anything more than ask the patient what the child’s eligibility status is and then record the response. TVFC provides a Patient Eligibility Screening Form that can be used for this.

Question 13: Why must providers complete a Provider Profile describing patients by eligibility category?

Answer: This information allows the Texas Department of State Health Services to determine how the cost of vaccine will be divided among state and federal funds. Each year, you may find your profile information has changed. The Provider Profile must be updated annually, in accordance with Federal requirements.
APPENDIX B: IMMUNIZATIONS

B.1 Immunizations Overview ............................................................... CH-326
   B.1.1 Vaccine Adverse Event Reporting System (VAERS)..................... CH-326
   B.1.2 TVFC Versus Non-TVFC Vaccines/Toxoids .............................. CH-326
   B.1.3 Exemption from Immunization for School and Child-Care Facilities .... CH-326

B.2 Recommended Childhood Immunization Schedule ......................... CH-327
   B.2.1 Recommended Childhood and Adolescent Immunization Schedule, 2013 .... CH-328

B.3 General Recommendations ......................................................... CH-332
   B.3.1 How to Obtain Vaccines at No Cost to the Provider ....................... CH-332
   B.3.2 Administrations and Immunizations ........................................... CH-332
       B.3.2.1 Administrations .......................................................... CH-332
       B.3.2.2 Immunizations (Vaccine/Toxoids) ..................................... CH-332
   B.3.3 Requirements for TVFC Providers ............................................ CH-333
   B.3.4 How to Report Immunization Records to ImmTrac, the Texas Immunization
       Registry .................................................................................. CH-334
       B.3.4.1 Direct Internet Entry ....................................................... CH-334
       B.3.4.2 Electronic Data Transfer (Import) ....................................... CH-335
       B.3.4.3 Obtaining Parental Consent for Registry Participation .............. CH-335

B.4 Texas Vaccines for Children Program Packet .............................. CH-335
B.1 Immunizations Overview

Clients who are 17 years of age and younger must be immunized according to the Recommended Childhood Immunization Schedule for the United States. If the immunizations are due as part of a Texas Health Steps (THSteps) medical checkup, the medical checkup provider is responsible for the administration of immunizations for clients who are birth through 20 years of age and may not refer clients to local health departments. The Department of State Health Services (DSHS) requires that immunizations be administered during the THSteps medical checkup, unless they are medically contraindicated or excluded from immunization for reasons of conscience, including a religious belief.

Providers, in both public and private sectors, are required by federal mandate to provide a Vaccine Information Statement (VIS) to the responsible adult accompanying a client for an immunization. These statements are specific to each vaccine and inform the responsible adult about the risks and benefits. It is important that providers use the most current VIS.

Providers interested in obtaining copies of current VISs and other immunization forms or literature may call the DSHS Immunization Branch at (512) 458-7284. VISs may also be downloaded from the DSHS Immunization Branch website at www.immunizetexas.com.

B.1.1 Vaccine Adverse Event Reporting System (VAERS)

The National Childhood Vaccine Injury Act of 1986 (NCVIA) requires health-care providers to report:

- Any reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the Reportable Events Table that occurs within the specified time period after vaccination.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event.

Note: Documentation of the injection site is recommended but not required. For additional information about documentation, providers can refer to www.vaers.hhs.gov.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from http://vaers.hhs.gov/resources/vaersmaterialspublications.

B.1.2 TVFC Versus Non-TVFC Vaccines/Toxoids

When single antigen vaccines/toxoids or comparable antigen vaccines/toxoids are available for distribution through the Texas Vaccines for Children (TVFC) Program, but the provider chooses to use a different Advisory Committee on Immunization Practices (ACIP)-recommended product, the vaccine/toxoid will not be reimbursed; however, the administration fee will be considered.

Note: All administered vaccines/toxoids must be reported to DSHS. DSHS submits all vaccines/toxoids reported with consent to a centralized immunization registry, known as ImmTrac.

Refer to: Subsection B.3.4, “How to Report Immunization Records to ImmTrac, the Texas Immunization Registry” in this appendix.

B.1.3 Exemption from Immunization for School and Child-Care Facilities

Parents may obtain an exemption from immunization requirements for school and childcare entry for reasons of conscience or religious beliefs. An exemption is also available for clients who are medically contraindicated from receiving a vaccine. For more information on exemptions call (512) 458-7284, or visit www.immunizetexas.com.

Refer to: Section 5, “THSteps Medical” in this handbook.
B.2 Recommended Childhood Immunization Schedule

The Recommended Childhood Immunization Schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. This schedule was developed and approved by ACIP, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Some combination vaccines are available and may be used whenever any component of the combination is indicated and its other components are not contraindicated. Providers should consult the manufacturer’s package insert for detailed recommendations.

Vaccines should be administered at the recommended ages. Any dose not given at the recommended age should be given as a catch-up immunization on any subsequent visit when indicated and feasible.

A current copy of the Recommended Childhood Immunization Schedule can be accessed at www.cdc.gov/vaccines/schedules/index.htm.
Figure 1. Recommended immunization schedule for persons aged 0 through 18 years – 2013.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are in bold.

This schedule includes recommendations in effect as of January 1, 2013. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (http://www.cdc.gov/vaccines) or by telephone (800-CDC-INFO 800-232-4636).

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/acip/index.html), the American Academy of Pediatrics (http://www.aap.org), the American Academy of Family Physicians (http://www.aafp.org), and the American College of Obstetricians and Gynecologists (http://www.acog.org).

NOTE: The above recommendations must be read along with the footnotes of this schedule.
FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind — United States, 2013

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

### Persons aged 4 months through 6 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dose 1 to dose 2</td>
<td>Dose 2 to dose 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 weeks and at least 16 weeks after first dose; minimum age for the final dose is 24 weeks</td>
</tr>
<tr>
<td>Hepatitis B&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Birth</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Rotavirus&lt;sup&gt;2&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Diphtheria, tetanus, pertussis&lt;sup&gt;3&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Haemophilus influenzae type b&lt;sup&gt;4&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks if first dose administered at younger than age 7 months</td>
</tr>
<tr>
<td>Pneumococcal&lt;sup&gt;5&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks if first dose administered at older or current age 24 through 59 months</td>
</tr>
<tr>
<td>Inactivated poliovirus&lt;sup&gt;6&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Meningococcal&lt;sup&gt;6,7&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Measles, mumps, rubella&lt;sup&gt;6&lt;/sup&gt;</td>
<td>12 months</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Varicella&lt;sup&gt;8&lt;/sup&gt;</td>
<td>12 months</td>
<td>3 months</td>
</tr>
<tr>
<td>Hepatitis A&lt;sup&gt;9&lt;/sup&gt;</td>
<td>12 months</td>
<td>6 months</td>
</tr>
</tbody>
</table>

### Persons aged 7 through 18 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dose 1 to dose 2</td>
<td>Dose 2 to dose 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 weeks if first dose administered at younger than age 7 months</td>
</tr>
<tr>
<td>Tetanus, diphtheria; tetanus, diphtheria, pertussis&lt;sup&gt;9&lt;/sup&gt;</td>
<td>7 years&lt;sup&gt;4&lt;/sup&gt;</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Human papillomavirus&lt;sup&gt;10&lt;/sup&gt;</td>
<td>9 years&lt;sup&gt;&lt;sup&gt;4&lt;/sup&gt;&lt;/sup&gt;</td>
<td>4 weeks if first dose administered at younger than age 12 months</td>
</tr>
<tr>
<td>Hepatitis A&lt;sup&gt;11&lt;/sup&gt;</td>
<td>12 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Hepatitis B&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Birth</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Inactivated poliovirus&lt;sup&gt;6&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Meningococcal&lt;sup&gt;6,7&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Measles, mumps, rubella&lt;sup&gt;6&lt;/sup&gt;</td>
<td>12 months</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Varicella&lt;sup&gt;8&lt;/sup&gt;</td>
<td>12 months</td>
<td>3 months if person is younger than age 13 years</td>
</tr>
</tbody>
</table>

**NOTE:** The above recommendations must be read along with the footnotes on pages 4–5 of this schedule.
Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2013

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/pubs/acip-list.htm.

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)

Routine vaccination:
- At birth
  - Administer monovalent HepB vaccine to all newborns before hospital discharge.
- For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after completion of the HepB series, at age 9 through 18 months (preferably at the next well-child visit).
- If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine to all infants regardless of birth weight. For infants weighing <2,000 grams, administer HBIG in addition to HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if she is HBsAg-positive, also administer HBIG for infants weighing ≥2,000 grams (no later than age 1 week).

Doses following the birth dose
- The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
- Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0, 1 to 2 months, and 6 months starting as soon as feasible. See Figure 2.
- The minimum interval between dose 1 and dose 2 is 4 weeks and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks, and at least 16 weeks after the first dose.
- Administration of a total of 4 doses of HepB vaccine is recommended when a combination vaccine containing HepB is administered after the birth dose.

Catch-up vaccination:
- Unvaccinated persons should complete a 3-dose series.
  - A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children age 11 through 15 years.
- For other catch-up issues, see Figure 2.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV-1 [Rotarix] and RV-5 [RotaTeq]).

Routine vaccination:
- Administer a series of RV vaccine to all infants as follows:
  1. If RV-1 is used, administer a 2-dose series at 2 and 4 months of age.
  2. If RV-5 is used, administer a 3-dose series at ages 2, 4, and 6 months.
  3. If any dose in series was RV-5 or vaccine product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.

Catch-up vaccination:
- The maximum age for the first dose in the series is 14 weeks, 6 days.
- Vaccination should not be initiated for infants aged 15 weeks 6 days or older.
- The maximum age for the final dose in the series is 8 months, 0 days.
- If RV-1 (Rotarix) is administered for the first and second doses, a third dose is not indicated.
- For other catch-up issues, see Figure 2.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

Routine vaccination:
- Administer a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15–18 months, and 4 through 6 years. The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

Catch-up vaccination:
- The fifth (booster) dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 years or older.
- For other catch-up issues, see Figure 2.

4. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for Boostrix, 11 years for Adacel).

Routine vaccination:
- Administer 1 dose of Tdap vaccine to all adolescents aged 11 through 12 years.
- Tdap can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Administer one dose of Tdap vaccine to pregnant adolescents during each pregnancy (preferred during 27 through 36 weeks gestation) regardless of number of years from prior Td or Tdap vaccination.

Catch-up vaccination:
- Persons aged 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series, should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. For these children, an adolescent Tdap vaccine should not be given.
- Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
- An inadvertent dose of DTaP vaccine administered to children aged 7 through 10 years can count as part of the catch-up series. This dose can count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11–12 years.
- For other catch-up issues, see Figure 2.

5. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

Routine vaccination:
- Administer a Hib vaccine primary series and a booster dose to all infants. The primary series doses should be administered at 2, 4, and 6 months of age; however, if PRP-OmP (PedvaxHib or Convivax) is administered at 2 and 4 months of age, a dose at age 6 months is not indicated. One booster dose should be administered at age 12 through 15 months.
- Hibrix (PRP-T) should only be used for the booster (final) dose in children aged 12 months through 4 years, who have received at least 1 dose of Hib.

Catch-up vaccination:
- If dose 1 was administered at ages 12–14 months, administer booster (as final dose) at least 8 weeks after dose 1.
- If the first 2 doses were PRP-OmP (PedvaxHib or Convivax), and were administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months, regardless of Hib vaccine (PRP-T or PRP-OmP) used for first dose.
- For unvaccinated children aged 15 months or older, administer only 1 dose.
- For other catch-up issues, see Figure 2.

Vaccination of persons with high-risk conditions:
- Hib vaccine is not routinely recommended for patients older than 5 years of age. However one dose of Hib vaccine should be administered to unvaccinated or partially vaccinated persons aged 5 years or older who have leukemia, malignant neoplasms, anatomic or functional asplenia (including sickle cell disease), human immunodeficiency virus (HIV) infection, or other immunocompromising conditions.

6a. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

Routine vaccination:
- Administer a series of PCV13 vaccine at ages 2, 4, 6 months with a booster at age 12 through 15 months.
- For children aged 14 through 59 months who have received an age-appropriate series of 7-valent PCV (PCV7), administer a single supplemental dose of 13-valent PCV (PCV13).

Catch-up vaccination:
- Administer 1 dose of PCV13 to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- For other catch-up issues, see Figure 2.

Vaccination of persons with high-risk conditions:
- For children aged 24 through 71 months with certain underlying medical conditions (see footnote 6c), administer 1 dose of PCV13 if 3 doses of PCV were received previously, or administer 2 doses of PCV13 at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
- A single dose of PCV13 may be administered to previously unvaccinated children aged 6 through 18 years who have anatomic or functional asplenia (including sickle cell disease), HIV infection or an immunocompromising condition, cochlear implant or cerebrospinal fluid leak. See MMWR 2010;59 (No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.
- An additional dose of PCV13 may be administered to children aged 2 years or older with certain underlying medical conditions (see footnotes 6b and 6c).

6b. Pneumococcal polysaccharide vaccine (PPSV23). (Minimum age: 2 years)

Vaccination of persons with high-risk conditions:
- Administer PPSV23 at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions (see footnote 6c). A single revaccination with PPSV23 should be administered after 5 years to children with anatomic or functional asplenia (including sickle cell disease) or an immunocompromising condition.

6c. Medical conditions for which PPSV23 is indicated in children aged 2 years and older and for which use of PCV13 is indicated in children aged 24 through 71 months:

- Immunocompetent children with chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy), diabetes mellitus; cerebrospinal fluid leaks; or cochlear implant.
- Children with anatomic or functional asplenia (including sickle cell disease and other hemoglobinopathies, congenital or acquired asplenia, or splenic dysfunction).
- Children with immunocompromising conditions: HIV infection, chronic renal failure and nephrotic syndrome, diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas and Hodgkin disease; or solid organ transplantation, congenital immunodeficiency.
7. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 months)
Routine vaccination:
- Administer a series of IPV at ages 2, 4, 6–18 months, with a booster at age 4–6 years. The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

Catch-up vaccination:
- In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
- If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years.
- A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child’s current age.
- IPV is not routinely recommended for U.S. residents aged 18 years or older.
- For other catch-up issues, see Figure 2.

8. Influenza vaccines. (Minimum age: 6 months for inactivated influenza vaccine [IIV]; 2 years for live, attenuated influenza vaccine [LAIV])
Routine vaccination:
- Administer influenza vaccine annually to all children beginning at age 6 months. For most healthy, nonpregnant persons aged 2 through 49 years, either LAIV or IIV may be used. However, LAIV should NOT be administered to some persons, including (1) those with asthma, (2) children 2 through 4 years who had wheezing in the past 12 months, or (3) those who have any other underlying medical conditions that predispose individuals to influenza complications. For all other contraindications to use of IAV (see MMWR 2010; 59:59 [No. RR-4], available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf).
- Administer 1 dose to persons aged 9 years and older.
- For children aged 6 months through 8 years:
  - For the 2013–14 season, follow dosing guidelines in the 2013 ACIP influenza vaccine recommendations.

9. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)
Routine vaccination:
- Administer the first dose of MMR vaccine at age 12 through 15 months, and the second dose at age 4 through 6 years. The second dose may be administered before age 4 years, provided that at least 4 weeks have elapsed since the first dose.
- Administer 1 dose of MMR vaccine to infants aged 6 through 11 months before departure from the United States for international travel. These children should be revaccinated with 2 doses of MMR vaccine, the first at age 12 through 15 months (12 months if the child remains in an area where disease risk is high), and the second dose at least 4 weeks later.
- Administer 2 doses of MMR vaccine to children aged 12 months and older, before departure from the United States for international travel. The first dose should be administered or if after age 12 months and the second dose at least 4 weeks later.

Catch-up vaccination:
- Ensure that all school-aged children and adolescents have had 2 doses of MMR vaccine; the minimum interval between the 2 doses is 4 weeks.

10. Varicella (VAR) vaccine. (Minimum age: 12 months)
Routine vaccination:
- Administer the first dose of VAR vaccine at age 12 through 15 months, and the second dose at age 4 through 6 years. The second dose may be administered before age 4 years, provided that at least 3 months have elapsed since the first dose. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
- For children aged 7 through 12 years the recommended minimum interval between doses is 3 months if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

Catch-up vaccination:
- Ensure that all persons aged 7 through 18 years without evidence of immunity (see MMWR 2007;56 [No. RR-4], available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2 doses of varicella vaccine. For children aged 7 through 12 years the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid), for persons aged 13 years and older, the minimum interval between doses is 4 weeks.

11. Hepatitis A vaccine (HepA). (Minimum age: 12 months)
Routine vaccination:
- Initiate the 2-dose HepA vaccine series for children aged 12 through 23 months; separate the 2 doses by 6 to 18 months.
- Children who have received 1 dose of HepA vaccine before age 24 months, should receive a second dose 6 to 18 months after the first dose.
- For any person aged 2 years and older who has not already received the HepA vaccine series, 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against hepatitis A virus infection is desired.

Catch-up vaccination:
- The minimum interval between the two doses is 6 months.

Special populations:
- Administer 2 doses of Hep A vaccine at least 6 months apart to previously unvaccinated persons who live in areas where vaccination programs target older children, or who are at increased risk for infection.

12. Human papillomavirus (HPV) vaccines. (HPV4 [Gardasil] and HPV2 [Cervarix]). (Minimum age: 9 years)
Routine vaccination:
- Administer a 3-dose series of HPV vaccine on a schedule of 0, 1–2, and 6 months to all adolescents aged 11–12 years. Either HPV4 or HPV2 may be used for females, and only HPV4 may be used for males.
- The vaccine series can be started beginning at age 9 years.
- Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).

Catch-up vaccination:
- Administer the vaccine series to females (either HPV4 or HPV4) and males (HPV4) at age 13 through 18 years if not previously vaccinated.

- Use recommended routine dosing intervals (see above) for vaccine series catch-up.

13. Meningococcal conjugate vaccines (MCV). (Minimum age: 6 weeks for Hib-MenCY, 9 months for Menactra [MCV4-D], 2 years for Menveo [MCV4-CRM]).
Routine vaccination:
- Administer MCV4 vaccine at age 11–12 years, with a booster dose at age 16 years.
- Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of MCV4, with at least 8 weeks between doses. See MMWR 2011;60:1018–1019 available at http://www.cdc.gov/mmwr/pdf/ww/mm6030.pdf.
- For children aged 2 months through 10 years with high-risk conditions, see below.

Catch-up vaccination:
- Administer MCV4 vaccine at age 13 through 18 years if not previously vaccinated.
- If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks between doses.
- If the first dose is administered at age 16 years or older, a booster dose is not needed.
- For other catch-up issues, see Figure 2.

Vaccination of persons with high-risk conditions:
- For children younger than 19 months of age with anatomic or functional asplenia (including sickle cell disease), administer an infant series of Hib-MenCY at 2, 4, 6, and 12–15 months.
- For children aged 2 through 18 months with persistent complement component deficiency, administer either an infant series of Hib-MenCY at 2, 4, 6, and 12 through 18 months or a 2-dose primary series of MCV4-D starting at 9 months, with at least 8 weeks between doses. For children aged 19 through 23 months with persistent complement component deficiency who have not received a complete series of Hib-MenCY or MCV4-D, administer 2 primary doses of MCV4-D at least 8 weeks apart.
- For children aged 24 months and older with persistent complement component deficiency or anatomic or functional asplenia (including sickle cell disease), who have not received a complete series of Hib-MenCY or MCV4-D, administer 2 primary doses of either MCV4-D or MCV4-CRM. If MCV4-D (Menactra) is administered to a child with asplenia (including sickle cell disease), do not administer MCV4-D until 2 years of age and at least 4 weeks after the completion of all PCV13 doses. See MMWR 2011;60:1391–2, available at http://www.cdc.gov/mmwr/pdf/ww/mm6040.pdf.
- For children aged 9 months and older who are residents of or travelers to countries in the African meningitis belt or to the Hajj, administer an age appropriate formulation and series of MCV4 for protection against serogroups A and W-135. Prior receipt of Hib-MenCY is not sufficient for children traveling to the meningitis belt or the Hajj. See MMWR 2011;60:1391–2, available at http://www.cdc.gov/mmwr/pdf/ww/mm6040.pdf.
- For children who are present during outbreaks caused by a vaccine serogroup, administer or complete an age and formulation-appropriate series of Hib-MenCY or MCV4.
- For booster doses among persons with high-risk conditions refer to http://www.cdc.gov/vaccines/pubs/acip-list.htm#mening.
B.3 General Recommendations
For information about vaccine administration, dosing, and contraindications, immunization providers should consult vaccine package inserts and the January 28, 2011, issue of the Center for Disease Control and Prevention Morbidity and Mortality Weekly Report (MMWR). For copies of the MMWR, contact the Immunization Branch at (512) 458-7284.

B.3.1 How to Obtain Vaccines at No Cost to the Provider
TVFC provides routinely recommended ACIP vaccines for immunization of THSteps and other Medicaid- and TVFC-eligible clients free of charge to providers who are enrolled in TVFC. The local health department/district or DSHS regional office provides information on how to order, account for, and inventory vaccines. Monthly reports are required in order to receive state-purchased vaccines. Physicians who request and accept state-supplied vaccines must complete and sign the provider enrollment and profile forms annually. The provider may not charge Medicaid or the client for vaccines obtained from TVFC.

Additional information is available at www.immunizetexas.com.

B.3.2 Administrations and Immunizations

B.3.2.1 Administrations
The following administration procedure codes must be submitted in combination with an appropriate vaccine/toxoid procedure code:

<table>
<thead>
<tr>
<th>Administration Procedure Code</th>
<th>90460</th>
<th>90461</th>
<th>90471</th>
<th>90472</th>
<th>90473</th>
<th>90474</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Code</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered. Documentation of counseling by the physician or other qualified health-care professional must be noted in the client’s medical record.

Procedure codes 90471, 90472, 90473, and 90474 are benefits for services rendered to clients of any age when counseling is not provided for the immunization administered.

B.3.2.2 Immunizations (Vaccine/Toxoids)
The following vaccines and toxoids are a benefit of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Number of Components**</th>
<th>Procedure Code</th>
<th>Number of Components**</th>
<th>Procedure Code</th>
<th>Number of Components**</th>
</tr>
</thead>
<tbody>
<tr>
<td>90632</td>
<td>1</td>
<td>90633*</td>
<td>1</td>
<td>90636</td>
<td>2</td>
</tr>
<tr>
<td>90644</td>
<td>2</td>
<td>90647*</td>
<td>1</td>
<td>90648*</td>
<td>1</td>
</tr>
<tr>
<td>90649*</td>
<td>1</td>
<td>90650*</td>
<td>1</td>
<td>90654</td>
<td>1</td>
</tr>
<tr>
<td>90655*</td>
<td>1</td>
<td>90656*</td>
<td>1</td>
<td>90657*</td>
<td>1</td>
</tr>
<tr>
<td>90658*</td>
<td>1</td>
<td>90660*</td>
<td>1</td>
<td>90669</td>
<td>1</td>
</tr>
<tr>
<td>90670*</td>
<td>1</td>
<td>90672*</td>
<td>1</td>
<td>90680*</td>
<td>1</td>
</tr>
<tr>
<td>90681*</td>
<td>1</td>
<td>90686*</td>
<td>1</td>
<td>90696*</td>
<td>4</td>
</tr>
<tr>
<td>90698*</td>
<td>5</td>
<td>90700*</td>
<td>3</td>
<td>90702*</td>
<td>2</td>
</tr>
<tr>
<td>90703</td>
<td>1</td>
<td>90707*</td>
<td>3</td>
<td>90710*</td>
<td>4</td>
</tr>
<tr>
<td>90713*</td>
<td>1</td>
<td>90714*</td>
<td>2</td>
<td>90715*</td>
<td>3</td>
</tr>
<tr>
<td>90716*</td>
<td>1</td>
<td>90721</td>
<td>4</td>
<td>90723*</td>
<td>5</td>
</tr>
</tbody>
</table>
Providers may use the state-defined modifier U1 in addition to the associated administered vaccine procedure code for clients who are birth through 18 years of age and the vaccine was unavailable through TVFC.

**Note:** “Unavailable” is defined as a new vaccine approved by ACIP that has not been negotiated or added to a TVFC contract, funding for new vaccine that has not been established by TVFC, or national supply or distribution issues. Providers will be informed if a vaccine meets the definition of ‘not available’ from TVFC and when the provider’s privately purchased vaccine may be billed with modifier U1.

Modifier U1 may not be used for failure to enroll in TVFC, maintain sufficient TVFC vaccine/toxoid inventory, or for clients who are 19 through 20 years of age.

### B.3.3 Requirements for TVFC Providers

By enrolling, public and private providers agree to:

- Screen patients for TVFC eligibility at all immunization encounters, and administer TVFC-purchased vaccines only to clients who are 18 years of age and younger who meet one or more of the following criteria:
  - Is an American Indian or Alaska Native.
  - Is enrolled in Medicaid.
  - Has no health insurance.
  - Is underinsured: clients who have other health insurance but the coverage does not include vaccines, clients whose insurance covers only selected vaccines (TVFC-eligible for noncovered vaccines only), clients whose insurance capitates vaccine coverage at a certain amount (once that coverage amount is reached, these clients are categorized as underinsured).
  - Is a client who receives benefits from the Children’s Health Insurance Program (CHIP) and the provider bills CHIP for the administration fee.
- Maintain all records related to the TVFC program, including parent, guardian, or authorized representative’s responses to screening for patient’s eligibility for at least three years. If requested, the provider will make such records available to DSHS, the local health department authority, or the U.S. Department of Health and Human Services (HHS).
- Comply with the appropriate vaccination schedule, dosage, and contraindications, as established by ACIP, unless (a) in making a medical judgment in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas law, including laws relating to religious and medical exemptions.

### Modifier Description

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>State-defined modifier: Vaccines/toxoids privately purchased by provider when TVFC vaccine/toxoid is unavailable</td>
</tr>
</tbody>
</table>

* TVFC-distributed vaccine/toxoid

** The number of components applies if counseling is provided and procedure codes 90460 and 90461 are submitted.
- Provide VISs to the responsible adult, parent, or guardian, and maintain records in accordance with the NCVIA which include reporting clinically significant adverse events to VAERS. Signatures are required for informed consent. (The Texas Addendum portion of the VIS may be used to document informed consent.)

- Not charge for vaccines supplied by DSHS and administered to a client who is eligible for TVFC.

- Charge a vaccine administration fee to Texas Medicaid but not impose a charge for the administration of the vaccine in any amount higher than the maximum administration fee established by DSHS (providers may charge a vaccine administration fee to Medicaid, but not a fee for the vaccine). Medicaid clients cannot be charged any out-of-pocket expense for the vaccine or the administration of the vaccine.

- Not deny administration of a TVFC vaccine to a client because of the inability of the client’s parent or guardian/individual of record to pay an administration fee.

- Comply with the state’s requirements for ordering vaccines and other requirements as described by DSHS, and operate within the TVFC program in a manner intended to avoid fraud and abuse.

- Allow DSHS (or its contractors) to conduct scheduled and unannounced storage and handling visits.

The provider or the state may terminate the agreement at any time for failure to comply with the requirements listed above. If the agreement is terminated for any reason, the provider agrees to properly return any unused vaccine.

**B.3.4 How to Report Immunization Records to ImmTrac, the Texas Immunization Registry**

Texas law requires all medical providers and payors to report all immunizations administered to clients who are 17 years of age and younger, to ImmTrac, the Texas immunization registry operated by DSHS (Texas Health and Safety Code §§161.007-161.009). Providers must report all immunization information within 30 days of administration of the vaccine, and payors must report within 30 days of receipt of data elements from a provider. Prior to reporting immunizations to ImmTrac, providers must first register for registry participation and access.

ImmTrac is a centralized repository of immunization histories for clients of all ages and is a free service and benefit available to all Texans. Registry information is confidential, and by law, may be released only to:

- The client or client’s parent, legal guardian, or managing conservator.
- The client’s physician, school, or licensed child-care facility in which the client is enrolled.
- Public health districts or local health departments.
- The insurance company, health maintenance organization, or other organization that pays for the provision of the client’s health-care benefits.
- A health-care provider authorized to administer a vaccine.
- A state agency that has legal custody of the client.

ImmTrac offers two methods for reporting immunizations to DSHS: direct internet entry into ImmTrac’s internet application and electronic data transfer (import).

**B.3.4.1 Direct Internet Entry**

This method allows providers to access and review clients’ immunization histories prior to administering vaccines. Providers then update their client’s immunization record directly into the ImmTrac web application after administering vaccines to the patient.
B.3.4.2 Electronic Data Transfer (Import)

This method allows providers to report immunizations from an electronic medical record (EMR) software application via extract file for import into ImmTrac. Providers may still have access to the ImmTrac web application to access and review their clients’ immunization histories before administering any vaccines.

Regardless of reporting option selected, all providers must first register for ImmTrac access and receive login credentials from ImmTrac Customer Support. To register for ImmTrac access, providers may obtain and complete an ImmTrac Registration Packet (for providers and schools) from www.immtrac.com or request it from ImmTrac Customer Support at 1-800-348-9158.

B.3.4.3 Obtaining Parental Consent for Registry Participation

Before including a client’s immunization information in ImmTrac, DSHS must verify that written consent for registry participation has been granted by the client’s parent, legal guardian, or managing conservator. Most parents grant consent for ImmTrac participation during the birth certificate registration process. Written parental consent for ImmTrac participation applies to all past, present, and future immunizations. Texas law also permits a parent, managing conservator, or guardian to withdraw consent for ImmTrac participation at any time.

Providers may offer parents the opportunity to grant consent for their child’s participation in ImmTrac using the pre-filled, ImmTrac-generated Immunization Registry (ImmTrac) Consent Form or the manual version (#C-7) of this form, also available from the ImmTrac application. Providers should retain the consent form and affirm parental consent via ImmTrac to establish the client’s ImmTrac record and report all immunizations administered and add any historical immunization information to the client’s record. Entering administered immunizations and historical immunization information to the client’s record constitutes “reporting” to ImmTrac as required by current Texas law.

B.4 Texas Vaccines for Children Program Packet

Refer to: Form A.6, “Texas Vaccines For Children (TVFC)” in Appendix A, “THSteps Forms,” in this handbook.


APPENDIX C: LEAD SCREENING

C.1 Blood Lead Screening Procedures and Follow-up Testing .......................... CH-338
C.2 Symptoms of Lead Poisoning ........................................................................ CH-338
C.3 Measuring Blood Lead Levels ...................................................................... CH-338
C.4 Environmental Lead Investigation Services .................................................. CH-339
   C.4.1 Enrollment ................................................................................................. CH-339
   C.4.2 Services, Benefits, Limitations, and Prior Authorization .......................... CH-339
      C.4.2.1 Requesting an Environmental Lead Investigation ............................... CH-339
      C.4.2.2 Prior Authorization ............................................................................. CH-340
   C.4.3 Documentation Requirements .................................................................. CH-340
   C.4.4 Claims Filing and Reimbursement ............................................................ CH-341
      C.4.4.1 Claims Filing ....................................................................................... CH-341
      C.4.4.2 Managed Care Clients ....................................................................... CH-341
      C.4.4.3 Reimbursement .................................................................................. CH-341
C.5 Form Pb-109: Reference for Follow-up Blood Lead Testing and Medical Case Management .............................................................. CH-342
C.6 Lead Poisoning Prevention Educational Materials and Forms ....................... CH-343
C.1 Blood Lead Screening Procedures and Follow-up Testing
For all children enrolled in Texas Health Steps (THSteps) blood lead testing is mandatory when they are 12 months of age and 24 months of age, or whenever they receive their first checkup after these ages if blood testing was not completed (up to and including the 6-year checkup). Lead-risk assessment should be done at all other checkups through age 6, and may be performed using Form PB 110, Lead Risk Questionnaire. A “yes” or “don’t know” answer to any question on the questionnaire indicates that a blood lead test should be administered. All blood lead levels in clients who are birth through 14 years of age must be reported to the Department of State Health Services (DSHS). Reports should include all information as required on the Texas Child Blood Lead Level Report Form F09-11709, which is available at www.dshs.state.tx.us/lead/providers.shtm or by calling 1-800-588-1248. Elevated blood lead levels (EBLLs) for clients who are 15 years of age or older must be reported and should include all information required on the Adult Blood Lead Report Form F09-11624.

C.2 Symptoms of Lead Poisoning
Children who have EBLLs in the range of 10–45μg/dL may be asymptomatic, although impairment of neurodevelopment may become evident as they get older. Very high lead levels may cause colic, constipation, anorexia, or vomiting. Children with venous blood lead levels (BLLs) over 44μg/dL are eligible for medical intervention. However, it is important not to equate the absence of symptoms with the absence of toxicity.

C.3 Measuring Blood Lead Levels
A blood lead test is the only definitive method to detect exposure. BLLs are measured as micrograms of lead per deciliter of whole blood (μg/dL). In Texas, a BLL requires medical case management and follow-up testing if the level is greater than or equal to 10 μg/dL.

Blood lead tests, in order of occurrence:
- Screening test—A blood lead test that indicates whether a client may have an EBLL. This test must be sent to the DSHS lab, or may be done using point-of-care technology in the provider’s office.
- Diagnostic test—A venous blood lead test that is performed within recommended guidelines to determine the status of a client who has previously had an EBLL on a screening test (See Form 342, “Form Pb-109: Reference for Follow-up Blood Lead Testing and Medical Case Management” in this appendix for recommended guidelines). Unless the diagnostic test is performed within four weeks of the screening date, it is not a diagnostic test but rather a new screening test.
- Follow-up test—A venous blood lead test to monitor the status of a client with a previously elevated diagnostic test for lead.

Note: A follow-up test is not related to the THSteps follow-up visit. A visit to monitor a child with EBLL would be submitted as an acute care evaluation and management (E/M) visit.

Providers are responsible for conducting a diagnostic test when a screening test finds a lead level of 10μg/dL or greater. Blood for a screening test may be drawn from a venous or capillary site. A venous blood draw is strongly recommended and preferred. To order free venous sample supplies from the DSHS Laboratory, call 1-888-963-7111, Ext. 7661.

Note: The capillary lead screen analysis is subject to a false positive result from skin lead contamination during collection. A soap and water wash of the patient’s hands or feet and the collector’s hands (or the wearing of gloves) must be performed to minimize the chance of contamination. Alcohol cleansing alone is not sufficient.

If the screening test is 10μg/dL or above, recalling a client for a diagnostic sample may be billed as a THSteps follow-up visit. If the screening test was rejected due to clotting, insufficient quantities, or perceived contamination, the provider must repeat the sample as a diagnostic test. Again, the provider may bill the visit and analysis as an E/M visit. Providers can submit the specimen to the DSHS Clinical
Chemistry Laboratory using the appropriate DSHS Laboratory Specimen Submission form (the same way as for all other THSteps laboratory blood specimens). If the initial blood lead test is collected as part of a THSteps medical checkup, it must either be sent to the DSHS lab or performed in the provider’s office using point-of-care. The diagnostic and follow-up test for the same client may be sent to a private laboratory.

Refer to: Form 342, “Form Pb-109: Reference for Follow-up Blood Lead Testing and Medical Case Management” in this appendix for interpretation of laboratory test results and guidelines for follow-up for clients with elevated blood lead levels.

Subsection 5.3.11.6.6, “* Required Laboratory Tests Related to Medical Checkups” in this handbook.

Subsection 5.3.9, “* Newborn Examination” in this handbook.

Providers can find more information about the medical and environmental management of lead-poisoned children on the DSHS Texas Childhood Lead Poisoning Prevention Program (TX CLPPP) website at www.dshs.state.tx.us/lead or by calling 1-800-588-1248.

C.4 Environmental Lead Investigation Services

C.4.1 Enrollment

State and local health departments that employ or contract certified lead risk assessors must be enrolled with Texas Medicaid as a THSteps provider to perform environmental lead investigation (ELI) services.

- State and local health departments that are currently enrolled in Texas Medicaid must complete the THSteps Provider Enrollment Application.
- State and local health departments that are not currently enrolled in Texas Medicaid must complete the Texas Medicaid Provider Enrollment Application and the THSteps Provider Enrollment Application.

C.4.2 Services, Benefits, Limitations, and Prior Authorization

ELI services must be billed with procedure code T1029, which is restricted to diagnosis codes 9849 and V1586. Texas Medicaid may only reimburse a state or local health department for the certified lead risk assessor’s time and activities during an onsite investigation of a client’s home or primary residence. Laboratory analysis of environmental substances (e.g., water, paint, or soil) is not a benefit of Texas Medicaid.

Children who have confirmed and persistent EBLLs may require an ELI to determine the source of the lead exposure. An ELI is completed in a client’s home or primary residence by a certified lead risk assessor to determine whether a lead hazard exists and, if so, whether the lead source could be the cause of the EBLL.

C.4.2.1 Requesting an Environmental Lead Investigation

For the purpose of requesting an ELI, a lead screening provider is a physician, nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) who conducts blood lead tests for a THSteps client. Lead screening providers may submit a request for an ELI after a blood lead test has been conducted and there is evidence of persistent and confirmed EBLLs for the client. An EBLL is defined as a BLL of 10μg/dL or higher.
An ELI may be considered medically necessary if the results of the most recent blood lead test indicate any of the following:

- A venous BLL result of 10μg/dL to 19μg/dL from two separate specimens conducted at least 12 weeks apart
- A venous BLL result of 20μg/dL or greater from one specimen

**Note:** The ELI must be requested as soon as possible and no later than 30 days after obtaining the most recent BLL that indicates medical necessity. The lead screening provider must maintain in the client’s medical record the ELI request and the documentation of the BLL that indicates medical necessity.

The lead screening provider can request an ELI by completing Form Pb-101 “Environmental Lead Investigation Request” and submitting it to the TX CLPPP. TX CLPPP will review the request and determine whether the criteria for an ELI have been met. If an ELI request meets the TX CLPPP criteria, TX CLPPP sends a referral for an ELI to a state or local health department that is enrolled as a THSteps provider so that it can be assigned to a certified lead risk assessor.

An ELI can be performed under one of the following circumstances:

- No previous investigation of the current home or primary residence has been performed.
- There is a change in the client’s current home or primary residence.

If a previous investigation of the current home or primary residence has been performed and there has been a change in the client’s residential environment, TX CLPPP will determine whether the criteria have been met for an additional ELI.

**C.4.2.2 Prior Authorization**

Prior Authorization is not required for ELI services.

**C.4.3 Documentation Requirements**

The state or local health department that is responsible for conducting the investigation must maintain the following documentation in the client’s medical record:

- The TX CLPPP fax transmittal cover sheet that refers the ELI request to the local health department. The cover sheet must include:
  - The site to be assessed.
  - A statement that identifies the site as the client’s primary place of residence.
- A completed Form Pb-101: Environmental Lead Investigation Request (two pages) that includes the:
  - Name of the referring lead screening provider.
  - BLLs that indicate medical necessity.
  - Client’s diagnosis (code 9849 or V1586).
- A completed Form Pb-103: Elevated Blood Lead Level Investigation Questionnaire (all pages) that includes the:
  - Date and location of the investigation.
  - Name of the client who received the investigation.
  - Identifying information and signature of the certified lead risk assessor who conducted the investigation. The person listed as the assessor must be the same person who signs the report.

**Note:** Forms Pb-101 and Pb-103 are located on the TX CLPPP website at www.dhs.state.tx.us/lead/providers.shtm.
C.4.4 Claims Filing and Reimbursement

C.4.4.1 Claims Filing

ELI services must be submitted to Texas Medicaid & Healthcare Partnership (TMHP) in an approved electronic format or on the CMS-1500 paper claim form. Providers can purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

The following documentation must be submitted with the claim:

- The TX CLPPP fax transmittal cover sheet that refers the ELI request to the state or local health department. The cover sheet must include:
  - The site to be assessed.
  - A statement that identifies the site as the client’s primary place of residence.
  - A completed Form Pb-101: Environmental Lead Investigation Request.
  - The first and last page of Form Pb-103: Elevated Blood Lead Level Investigation Questionnaire, which has been completed by the lead risk assessor.

An ELI is subject to retrospective review and may be recouped if the documentation maintained by the lead screening and ELI providers does not support medical necessity.

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

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

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims.

C.4.4.2 Managed Care Clients

ELI services are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client’s managed care organization (MCO).

C.4.4.3 Reimbursement

Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.
C.5 Form Pb-109: Reference for Follow-up Blood Lead Testing and Medical Case Management

Reference for Follow-up Blood Lead Testing and Medical Case Management

**Healthcare Provider:**
- Immediately retest the child if the blood lead test result is invalid due to “Clotted” or “Insufficient Quantity.”
- Follow the flowchart below to determine if or when follow-up testing and medical case management is necessary.

### Table 1: Schedule for Obtaining a Diagnostic Venous Sample

<table>
<thead>
<tr>
<th>Capillary Screening Test Result (mcg/dL)</th>
<th>Perform Venous Diagnostic Test Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-44</td>
<td>1 week - 4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>45-59</td>
<td>48 hours</td>
</tr>
<tr>
<td>60-69</td>
<td>24 hours</td>
</tr>
<tr>
<td>70 and up</td>
<td>Immediately as an emergency lab test</td>
</tr>
</tbody>
</table>

### Table 2: Schedule for Follow-Up Venous Blood Lead Testing

<table>
<thead>
<tr>
<th>Venous Blood Lead Level (mcg/dL)</th>
<th>Early Follow-up (first 2-4 tests after identification)</th>
<th>Late Follow-up (after BLL begins to decline)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>3 months</td>
<td>6-9 months</td>
</tr>
<tr>
<td>15-19</td>
<td>1-3 months</td>
<td>3-6 months</td>
</tr>
<tr>
<td>20-24</td>
<td>1-3 months</td>
<td>1-3 month</td>
</tr>
<tr>
<td>25-44</td>
<td>2 weeks - 1 month</td>
<td>1 month</td>
</tr>
<tr>
<td>45 and up</td>
<td>As soon as possible</td>
<td>Chelation with subsequent follow-up&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

### Table 3: Medical Case Management for Children with a Diagnostic Elevated Blood Lead Levels

<table>
<thead>
<tr>
<th>10-14 mcg/dL</th>
<th>15-19 mcg/dL</th>
<th>20-44 mcg/dL</th>
<th>45-69 mcg/dL</th>
<th>70 or higher mcg/dL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lead Education: Dietary &amp; Environmental</td>
<td>1. Lead Education: Dietary &amp; Environmental</td>
<td>1. Lead Education: Dietary &amp; Environmental</td>
<td>1. Lead Education: Dietary &amp; Environmental</td>
<td>1. Hospitalize and commence chelation therapy&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
<tr>
<td>2. Follow-up BLL monitoring</td>
<td>2. Follow-up BLL monitoring</td>
<td>2. Follow-up BLL monitoring</td>
<td>2. Follow-up BLL monitoring</td>
<td>2. Proceed according to actions for 45-69 mcg/dL</td>
</tr>
<tr>
<td>A follow-up BLL persists at least 12 weeks after diagnostic venous test</td>
<td>A follow-up BLL persists at least 12 weeks after diagnostic venous test, or BLLs increase</td>
<td>Lab work: Hemoglobin or hematocrit; Iron status</td>
<td>Lab work: Hemoglobin or hematocrit; Iron status; FEP or ZPP</td>
<td>Complete history and physical exam</td>
</tr>
<tr>
<td>7. Neurodevelopmental monitoring</td>
<td>8. Neurodevelopmental monitoring</td>
<td>Complete neurological exam</td>
<td>Abdominal X-ray (if particulate lead ingestion is suspected) with bowel decontamination if indicated</td>
<td>9. Abdominal X-ray with bowel decontamination if indicated</td>
</tr>
<tr>
<td>8. Neurodevelopmental monitoring</td>
<td>9. Abdominal X-ray with bowel decontamination if indicated</td>
<td>10. Chelation therapy&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Abdominal X-ray with bowel decontamination if indicated</td>
<td>Abdominal X-ray with bowel decontamination if indicated</td>
</tr>
</tbody>
</table>

<sup>a</sup>Blood Lead Screening and Testing Guidelines for Texas Children: Quick Reference Guide. Go to: www.dshs.state.tx.us/lead. <sup>b</sup>The higher the BLL on the screening test, the more urgent the need for diagnostic testing. <sup>c</sup>Healthcare providers should consult with an expert in the management of these lead levels before administering chelation. Chelation therapy should never be administered before a venous diagnostic is obtained. Contact your local Poison Control Center or contact Texas CLPPP for a referral.

Tables adapted from Managing Elevated Blood Lead Levels Among Young Children: CDC, March 2002

*Contact Texas Childhood Lead Poisoning Prevention Program PO BOX 149347 • Austin, TX 78714-9347 • 1-800-588-1248 • www.dshs.state.tx.us/lead*
C.6 Lead Poisoning Prevention Educational Materials and Forms

Providers may download lead poisoning prevention education materials and forms from the Texas CLPPP website at www.dshs.state.tx.us/lead.

The following table lists materials available to providers for download:

<table>
<thead>
<tr>
<th>Lead Poisoning Prevention Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-26 Protect Your Children From Lead Poisoning</td>
</tr>
<tr>
<td>1-26a Protect Your Children From Lead Poisoning (Spanish)</td>
</tr>
<tr>
<td>1-307 Lead Around the Home (English/Spanish, front and back)</td>
</tr>
<tr>
<td>1-308 Lead in Your Food and Remedies (English/Spanish, front and back)</td>
</tr>
<tr>
<td>1-309 Lead in the Workplace and at Home (English/Spanish, front and back)</td>
</tr>
<tr>
<td>1-310 My Child Has a High Lead Level (English/Spanish, front and back)</td>
</tr>
<tr>
<td>1-311 How Lead Affects Your Child’s Health (English/Spanish, front and back)</td>
</tr>
<tr>
<td>1-312 Educator’s Brochure</td>
</tr>
<tr>
<td>1-313 Getting a Good Specimen (Poster)</td>
</tr>
<tr>
<td>13-32 Get the Lead Out With Good Nutrition</td>
</tr>
<tr>
<td>Pb-100 Possible Sources of Lead Exposure: Interview Questions</td>
</tr>
<tr>
<td>Pb-101 Request for Environmental Investigation</td>
</tr>
<tr>
<td>Pb-102 Follow-up of an Elevated Blood Lead Level</td>
</tr>
<tr>
<td>Pb-103 Elevated Blood Lead Level Investigation Questionnaire</td>
</tr>
<tr>
<td>Pb-104 Physician Checklist for Parent Education Topics</td>
</tr>
<tr>
<td>Pb-109 Reference for Follow-up Blood Lead Testing and Medical Case Management</td>
</tr>
<tr>
<td>Pb-110 Lead Risk Questionnaire</td>
</tr>
</tbody>
</table>
APPENDIX D: TEXAS HEALTH STEPS STATUTORY STATE REQUIREMENTS

D.1 Legislative Requirements ......................................................... CH-346
D.2 Texas Health Steps (THSteps) Program ........................................ CH-346
D.3 Communicable Disease Reporting ............................................ CH-346
D.4 Early Childhood Intervention (ECI) Referrals ............................... CH-346
D.5 Parental Accompaniment .......................................................... CH-346
D.6 Newborn Blood Screening ......................................................... CH-347
D.7 Abuse and Neglect ................................................................. CH-347
   D.7.1 Requirements for Reporting Abuse or Neglect ......................... CH-347
   D.7.2 Procedures for Reporting Abuse or Neglect ............................. CH-347
      D.7.2.1 Staff Training on Reporting Abuse and Neglect ................. CH-348
D.1 Legislative Requirements
Several specific legislative requirements affect Texas Health Steps (THSteps) and the provider's participation in Texas Medicaid. The legislation includes, but is not limited to, those included in this Appendix.

D.2 Texas Health Steps (THSteps) Program
The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is mandated by Title XIX of the Social Security Act. EPSDT is a program of prevention, diagnosis, and treatment for Medicaid-eligible clients who are birth through 20 years of age.

In Texas, EPSDT is known as THSteps. The Texas Department of State Health Services (DSHS), by authorization of Texas Department of Health and Human Services (HHSC), operates and administers the outreach and informing, medical and dental checkup, dental treatment utilization components of this program. State authority is found in Title 25 Texas Administrative Code (TAC), Part 1, Chapter 33, Subchapter A, Rule §33.1.

D.3 Communicable Disease Reporting
Diagnosis of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are reportable conditions under 25 TAC, Chapter 97, Subchapter F. Providers must report confirmed diagnosis of STDs as required by 25 TAC §§97.132-134.

D.4 Early Childhood Intervention (ECI) Referrals
All health-care professionals are required by federal and state regulations to refer children who are birth through 35 months of age to the Texas ECI Program as soon as possible, but no longer than 7 days after identifying a disability or suspected delay in development.

Referrals can be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

To refer families for services, providers can call their local ECI program, or they can call the Department of Assistive and Rehabilitative Services (DARS) Inquiry Line at 1-800-628-5115.

To facilitate referrals for ECI services an optional form is available on the Texas Pediatric Society website at http://txpeds.org/eci.

For additional ECI information, providers can visit the DARS website at www.dars.state.tx.us/ecis.
Persons who are deaf or hard of hearing can call the TDD/TTY Line at 1-866-581-9328.

D.5 Parental Accompaniment
Texas Human Resource Code (HRC) §§32.024(s)-(s-1) requires that, as a condition for provider reimbursement, a client who is 14 years of age or younger be accompanied by the client’s parent, guardian, or other authorized adult during medical and dental checkups and dental treatment. DSHS implemented this requirement through rules found in 25 TAC §33.2 (Definitions) and 25 TAC §33.6 (THSteps Provider Responsibilities).

The DSHS rules require that the parent, guardian, or authorized adult accompany the client to the checkup, and that the parent, guardian, or authorized adult must wait for the client while the checkup, treatment, or service takes place.
Providers will not be required to submit documentation to TMHP to verify compliance with this policy in order for TMHP to process claims. By submitting the claim for reimbursement, the provider acknowledges compliance with all Medicaid requirements. Additional assurances are not necessary.

**Exception:** School health clinics, Head Start programs, and childcare facilities are exempt from this policy if the clinic, program, or facility encourages parental involvement in the health care of the client and obtains written consent for the services. The consent from the client’s parent or guardian must have been received within the one-year period before the date on which the services are provided and must not have been revoked.

Refer to: HRC §§32.024(s)-(s-1) 25 TAC §33.2 and §33.6.

### D.6 Newborn Blood Screening

The Health and Safety Code (HSC), Chapter 33, Section §33.011, implemented by the rules found at 25 TAC, Part 1, Chapter 37, Subchapter D, requires testing of all newborns. A current list of disorders can be found at www.dshs.state.tx.us/newborn/screened_disorders.shtm.

This testing is the responsibility of the physician who is attending a newborn client (defined as up to 30 days of age by rule in 25 TAC, Chapter 37, Subchapter D, §37.52) or the person who is attending the delivery of a newborn client who is not attended by a physician to screen for the disorders within 24 to 48 hours of birth.

All infants must be tested a second time at 1 to 2 weeks of age. If there is any doubt that a client who is 12 months of age or younger was properly tested, the provider should submit a blood sample with the appropriate DSHS Form NBS3 to the DSHS Newborn Screening Laboratory.

### D.7 Abuse and Neglect

#### D.7.1 Requirements for Reporting Abuse or Neglect

Providers are required to report abuse or neglect as outlined in subsection 1.6, "Provider Responsibilities" in Section 1, "Provider Enrollment and Responsibilities" ([Vol. 1, General Information](#)).

Additionally, the General Appropriations Act, Article II, Rider 23 under DSHS, and Rider 13 under HHSC, of S.B. 1, 79th Legislative Regular Session, 2007, require that DSHS and HHSC distribute or provide appropriated funds only to recipients who show good faith efforts to comply with all child abuse and reporting requirements set forth in the Texas Family Code (TFC), Chapter 261, relating to investigations of reports of child abuse and neglect.

#### D.7.2 Procedures for Reporting Abuse or Neglect

Professionals, as defined in TFC §261.101 (b), are required to report abuse or neglect no later than the 48th hour after the hour in which the professional first has cause to believe the client has been or may be abused or is the victim of the offense of indecency with a child.

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

A report must be made regardless of whether the provider staff suspects that a report may have previously been made. Reports of abuse or indecency with a child should be made to one of the following:

- Texas Department of Family and Protective Services (DFPS), if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child (DFPS Texas Abuse Hotline, 1-800-252-5400, 24 hours a day, 7 days a week).
- Call the DFPS Texas Abuse Hotline if:
  - You believe your situation requires action in less than 24 hours.
  - You prefer to remain anonymous.
• You have insufficient data to complete the required information on the report.
• You do not want an email to confirm your report.

**Note:** Providers can also report nonemergency abuse online at www.txabusehotline.org.

• Any local or state law enforcement agency or the state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred.
• The agency designated by the court to be responsible for the protection of children.

The law requires that the report include the following:

• Name and address of the minor, if known.
• Name and address of the minor’s parent or the person responsible for the care, custody, or welfare of the child if not the parent, if known.
• Any other pertinent information concerning the alleged or suspected abuse, if known.

A provider may not reveal whether the client has been tested or diagnosed with HIV or acquired immunodeficiency syndrome (AIDS). If the minor’s identity is unknown (e.g., the minor is at the provider’s office to receive testing for HIV or an STD anonymously), no report is required.

**D.7.2.1 Staff Training on Reporting Abuse and Neglect**

All providers shall develop training for all staff on the policies and procedures in regard to reporting child abuse, including sexual abuse and neglect. New staff shall receive this training as part of their initial training or orientation.

Training shall be documented. As part of the training, staff shall be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.

Several specific legislative requirements affect THSteps and the provider’s participation in Texas Medicaid. The legislation includes, but is not limited to those included in this appendix.
APPENDIX E: HEARING SCREENING INFORMATION

E.1 Newborn Hearing (2 Pages) ................................................................. CH-350

E.2 Texas Early Hearing Detection and Intervention (TEHDI) Process .................. CH-352
   E.2.1 Birth Screen................................................................. CH-352
   E.2.2 Outpatient Rescreen .................................................. CH-352
   E.2.3 Evaluation using Texas Pediatric Protocol for Audiology ...................... CH-352
   E.2.4 Referral to an ECI Program.......................................... CH-353
   E.2.5 Periodic Monitoring by the Physician or Medical Home....................... CH-353

E.3 JCIH 2007 Position Statement .......................................................... CH-353
E.1 Newborn Hearing (2 Pages)
TEXAS EARLY HEARING DETECTION AND INTERVENTION (TEHDI)

1. Birth Screen
- Parental permission is required.
- Test is either Auditory Brainstem Response (ABR) or Transient or Distortion Product Otoacoustic Emissions (OAE).
- A second screen is done before discharge if the first is not passed.
- Written results are given to the parents and the baby's doctor.
- Results are reported to DSHS but identifying information is removed for infants who pass; parental permission is given for identified results to be reported.
- Referral to a local audiology/hearing resource is made for outpatient re-screen when an infant does not pass the second screen.

2. Outpatient Re-Screen
- ABR or OAE tests are used.
- If the infant does not pass, referrals are made to an audiologist for diagnostic hearing testing and to DARS/Early Childhood Intervention (ECI) by calling 1-800-628-5115.
- Hearing services are available for children who are eligible through the Texas Medicaid and Children with Special Healthcare Needs (CSHCN) programs.

3. Audiologic Evaluation
- Diagnostic ABR and, to verify cochlear involvement, OAE if not previously done.
- The Texas Pediatric Protocol for Evaluation is used; see www.dshs.state.tx.us/tehdi/assumpt.shtm.
- Results are reported to the referral source and to TEHDI.
- Referral is made to ECI upon the diagnosis of hearing loss.
- Referral to an otologist for a medical examination of the ear.
- Fitting of hearing aids by an audiologist when appropriate.
- Ongoing audiological assessment and monitoring as needed.

4. Referral to ECI
- Must be as soon as possible, but no longer than 7 days after diagnosis of hearing loss.
- Service coordination is provided by ECI.
- Parents may refuse ECI services.
- An Individual Family Services Plan (IFSP) will be developed by ECI within 45 days of referral.
- ECI and the Local Education Agency (LEA) have shared service responsibility for children with hearing loss birth to three. The LEA provides a certified teacher to work with families as outlined in the IFSP. ECI services are no cost to parents.
- ECI services are available until the child's third birthday, and then transition to the LEA is coordinated.

5. Deaf Education and other special education services are available from ages 3 – 21 when determined by the Individual Education Plan (IEP).

6. For children who pass the newborn hearing screen, the Medical Home/physician continues to monitor for developing hearing loss; see http://pediatrics.aappublications.org/cgi/content/full/120/4/898 for suggested monitoring protocols.

Additional Resources:
TEA – www.tea.state.tx.us
UT Caller Center - www.callier.utdallas.edu/txc.html

For more information about TEHDI call 800-252-8023 ext 7726 or 512-458-7726 or visit our website at www.dshs.state.tx.us/TEHDI/
05-1225B Revised 09/13
E.2 Texas Early Hearing Detection and Intervention (TEHDI) Process

The following processes for early hearing detection and intervention are addressed in this section:

- Birth screen
- Outpatient rescreen
- Evaluation using Texas Pediatric Protocol for Audiology
- Referral to an Early Childhood Intervention (ECI) program
- Periodic monitoring by the physician or medical home

E.2.1 Birth Screen

The hearing screen at birth will be either screening auditory brainstem response (ABR) or transient or distortion product otoacoustic emissions (OAE). The following items apply:

- A newborn’s hearing is screened at the birth facility. If a newborn does not pass the screen, hearing is rescreened before discharge.
- The birth facility reports results to the Department of State Health Services (DSHS) using the web-based eScreener Plus (eSP™) system.
- The newborn’s family and physician/medical home receive a written report of the hearing screen outcome.
- If a newborn passes the screen, the physician monitors hearing as part of well child checkups.
- If a newborn does not pass the second screen, a referral is made to a local resource who is experienced with the pediatric population for outpatient rescreen.

E.2.2 Outpatient Rescreen

If an outpatient rescreen is necessary, either ABR or OAE will be used. The following items apply:

- The physician/medical home receives the written report of results from the birth facility.
- The screener/physician reports results to the DSHS contractor, OZ Systems, using the web-based eSP™ system, by calling 1-866-427-5768 or faxing (817) 385-3939.
- If the newborn passes the outpatient rescreen, the physician monitors hearing as part of well child checkups.
- If a newborn does not pass the outpatient rescreen, a referral is made to an audiologist for evaluation using the Texas Pediatric Protocol for Evaluation. Visit www.dshs.state.tx.us/audio/assumpt.shtm for more information.
- Hearing services for clients who are birth through 20 years of age are administered through the Texas Medicaid hearing services benefit. Clients may use the Online Provider Lookup (OPL) to locate a Texas Medicaid provider who provides hearing services for children (clients who are birth through 20 years of age).

E.2.3 Evaluation using Texas Pediatric Protocol for Audiology

These evaluations will include a diagnostic ABR and, if not previously done, a diagnostic OAE will be performed to determine cochlear involvement. The following items apply:

- Audiologists use equipment norms for newborns, preferably ones that they have collected on their equipment.
- Protocols include air and bone conduction testing using tone burst ABR, as well as click ABR, so the amplification may be appropriately fit.
• The physician/medical home receives results and makes the referral to ECI using the web-based eSP™ system, by calling 1-800-628-5115, or by emailing the Texas Department of Assistive and Rehabilitative Services (DARS) at dars.inquiries@dars.state.tx.us.

• The physician/medical home monitors the child. See the American Academy of Pediatrics Position Statement at http://pediatrics.aappublications.org/cgi/content/full/113/Supplement_4/1545.

• The audiologist reports results to the DSHS contractor as noted above and makes the referral to ECI.

• Fitting of hearing aids by an audiologist when appropriate.

• Continued audiological assessment and monitoring as needed (usually monitor each three months for the first year of hearing aid use).

**E.2.4 Referral to an ECI Program**

The client will be referred to an ECI program by an audiologist or physician as soon as possible, but no longer than 7 days of identification of hearing loss as required by law. The following items apply:

• Service coordination provided by ECI.

• ECI will refer to the Local Education Agency (LEA) for auditory impairment (AI) services as outlined in the Memorandum of Understanding between TEA and DARS ECI.

• An evaluation and Individual Family Service Plan (IFSP) will occur within 45 days of referral to ECI.

• ECI services are available to clients birth through 35 months of age when determined by an IFSP.

• ECI and LEA will coordinate transition services upon the child’s third birthday.

**E.2.5 Periodic Monitoring by the Physician or Medical Home**

The physician/medical home will continue to monitor the client periodically and may consult or use the following:

• Providers may refer to the Joint Committee on Infant Hearing (JCIH) 2007 Position Statement for suggested monitoring protocols at http://pediatrics.aappublications.org/cgi/content/full/120/4/898.

• Deaf education and other special education services available from 3 years of age through 20 years of age when determined by an individualized education program.

• Regional specialists from Deaf and Hard of Hearing Services at the Department of Assistive and Rehabilitative Services (DARS) will provide technical assistance to birth facilities, audiologists, and ear, nose, and throat (ENT) physicians to ensure reporting of screening and evaluation results. Providers can call (512) 407-3250 for assistance.

**E.3 JCIH 2007 Position Statement**

The JCIH 2007 Position Statement is available on the JCIH website at www.jcih.org/posstatemts.htm. The 2007 Position Statement lists the indicators that are associated with permanent congenital, delayed-onset or progressive hearing loss in childhood.
# Texas Health Steps Quick Reference Guide

## THSteps Medical Checkup Billing Procedure Codes

### Immunizations Administered

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>90632 or 90633* with (90460/90461 or 90471/90472)</td>
<td>Hep A</td>
</tr>
<tr>
<td>90636 with (90460/90461 or 90471/90472)</td>
<td>Hep A/Hep B</td>
</tr>
<tr>
<td>90644</td>
<td>Hib-MenCY</td>
</tr>
<tr>
<td>90647* or 90648* with (90460/90461 or 90471/90472)</td>
<td>Hib</td>
</tr>
<tr>
<td>90649* or 90650* with (90460/90461 or 90471/90472)</td>
<td>HPV</td>
</tr>
<tr>
<td>90654, 90655*, 90656*, 90657*, 90658*, 90672*, or 90668* with (90460/90461 or 90471/90472)</td>
<td>Influenza</td>
</tr>
<tr>
<td>90660* with (90460/90461 or 90473/90474)</td>
<td></td>
</tr>
<tr>
<td>90669 or 90670* with (90460/90461 or 90471/90472)</td>
<td>PCV7, PCV13</td>
</tr>
<tr>
<td>90680 or 90681* with (90460/90461 or 90473/90474)</td>
<td>Rotavirus</td>
</tr>
<tr>
<td>90696* with (90460/90461 or 90471/90472)</td>
<td>DTaP-IPV</td>
</tr>
<tr>
<td>90698* with (90460/90461 or 90471/90472)</td>
<td>DTaP-IPV-Hib</td>
</tr>
<tr>
<td>90700* with (90460/90461 or 90471/90472)</td>
<td>DTaP</td>
</tr>
<tr>
<td>90702* with (90460/90461 or 90471/90472)</td>
<td>DT</td>
</tr>
<tr>
<td>90703 with (90460/90461 or 90471/90472)</td>
<td>Tetanus</td>
</tr>
<tr>
<td>90707* with (90460/90461 or 90471/90472)</td>
<td>MMR</td>
</tr>
</tbody>
</table>

* Indicates a vaccine distributed by TVFC

### Modifiers

#### Performing Provider

Use to indicate the practitioner who is performing the unclothed physical examination component of the medical checkup.

- AM
- SA
- TD
- U7

#### Exception to Periodicity

Use with THSteps medical checkups procedure codes to indicate the reason for an exception to periodicity.

- 23
- 32
- SC

#### FQHC and RHC

Federally qualified health center (FQHC) providers must use modifier EP for THSteps medical checkups. Rural health clinic (RHC) providers must bill place of service 72 for THSteps medical checkups.

#### Vaccine/Toxoids

Use to indicate a vaccine/toxoid not available through TVFC and the number of state defined components administered per vaccine.

- U1

Vaccine/toxoid privately purchased by provider when TVFC vaccine/toxoid is not available

#### Condition Indicator Codes

Use one of the indicators below if a referral was made.

<table>
<thead>
<tr>
<th>Condition Indicator</th>
<th>Condition Indicator Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>NU</td>
<td>Not used (no referral)</td>
</tr>
<tr>
<td>Y</td>
<td>ST</td>
<td>New services requested</td>
</tr>
<tr>
<td>Y</td>
<td>S2</td>
<td>Under treatment</td>
</tr>
</tbody>
</table>

CPT codes, descriptions, and other data only are copyright 2012 American Medical Association (or such other date of publication of CPT). All Rights Reserved. CPT is a trademark of the AMA. Applicable Federal Acquisition Regulation System/Department of Defense Regulation System (FARS/DFARS) restrictions apply to government use.
Contact Information

THSteps Medical Checkup Claims Inquiries
Call the following number to obtain answers to questions or determine the status of claims:
1-800-757-5691
For managed care clients, contact the client’s MCO.

THSteps Website
General information for THSteps providers including forms, details on the required components of checkups, and other helpful resources.
www.dshs.state.tx.us/thsteps/default.shtm
THSteps Child Health Record Forms and THSteps Provider Outreach Referral Form may be downloaded from the THSteps website at:
www.dshs.state.tx.us/thsteps/forms.shtm

THSteps Outreach & Informing Service
Information for THSteps clients to expand awareness of existing medical, dental, and case management services. Provider information to include missed appointment referral services.
1-877-THSteps (847-8377), Monday to Friday, 8am-8pm

THSteps Online Provider Education Website
Free comprehensive online continuing education modules designed for health-care providers. All modules provide continuing education units (CEUs) for multiple disciplines and include information about Texas Health Steps, Medicaid for children and other health-care services.
www.txhealthsteps.com

Case Management for Children and Pregnant Women
(512) 776-2168 | www.dshs.state.tx.us/caseman

Texas Immunization Registry (ImmTrac)
1-800-348-9158
www.dshs.state.tx.us/immunize/immtrac/default.shtm

Texas Vaccines for Children Program (TVFC)
1-800-252-9152
www.dshs.state.tx.us/immunize/tvfc/default.shtm

Early Childhood Intervention (ECI)
1-800-628-5115 | www.dars.state.tx.us/ecis

Vendor Drug Program (fee-for-service)
The Medicaid Vendor Drug Program makes payments to contracted pharmacies for prescriptions of covered outpatient drugs for Texas Medicaid, CSHCN Services Program, Kidney Health Care Program, and CHIP. Some Medicaid-covered drugs may require prior authorization (PA) through PA Texas.
Texas Prior Authorization Call Center:
1-800-728-3927
or online: https://paxpress.txpa.hidinc.com
(for prior authorizations of non-preferred drugs only)
General information, covered drug list, online pharmacy, and prescriber searches:
www.txvendordrug.com
www.hhsc.state.tx.us/medicaid/Chip-Pharmacy-Benefits.shtml
For managed care clients: Contact the client’s MCO.

Laboratory
Requests for THSteps laboratory supplies from the Department of State Health Services (DSHS) should be made on Form G399 and submitted to:

Container Preparation
Laboratory Services Section, MC 1947
Department of State Health Services
PO Box 149347
Austin, TX 78714-93471
For supply order inquiries, call (512) 776-7661 or 1-888-963-7111, Ext 7661
Fax: (512) 776-7672
For specimen shipping questions, call (512) 776-7569 or 1-888-963-7111, Ext 7669
For specimen collection and submission questions, call (512) 776-6236 or 1-888-963-7111 Ext 6236
For test result inquiries, call (512) 776-7578 or Fax (512) 776-7533.
Access THSteps test results online using the Clinical Chemistry Remote Data Services web application. To gain access, download, complete, and submit the required access forms are available at: www.dshs.state.tx.us/lab/remoteData.shtm.
For NBS testing questions, call (512) 776-7333 or 1-888-963-7111 Ext 7333.
A written request for Newborn Screening (NBS) specimen collection form (NBS3) and NBS supplies is required. To obtain an order form for written requests, call Container Preparation.
Access Newborn Screening test results online using the DSHS Newborn Screening Remote Data Services web application. To gain access, download, complete, and submit the required access forms available at: www.dshs.state.tx.us/lab/nbsRDSforms.shtm
For questions about submission requirements such as collection, supplies, and mailing of specimens for THSteps gonorrhea and chlamydia adolescent screening, contact DSHS Laboratory Customer Service at (512) 776-6030 or toll-free 1-888-963-7111, ext. 6030 or go to the DSHS website: www.dshs.state.tx.us/lab/default.shtm

Medicaid Fraud
To report potential Medicaid fraud:
HHSC Client or Provider Fraud Investigations:
1-800-436-6184
https://oig.hhsc.state.tx.us/Fraud_Report_Home.aspx

Childhood Lead Poisoning Prevention Program
1-800-588-1248
www.dshs.state.tx.us/lead/default.shtm

Comprehensive Care Program (CCP)
Telephone: 1-800-846-7470
Fax: (512) 514-4212

Medical Transportation Program (MTP)
1-877-633-8747 | www.hhsc.state.tx.us/QuickAnswers

Texas Medicaid & Healthcare Partnership (TMHP)
www.tmhp.com

Resource Catalog
Online order system for THSteps publications.
www.dshs.state.tx.us/thsteps/THStepsCatalog.shtm
APPENDIX G: THSTEPS DENTAL GUIDELINES

G.1 American Academy of Pediatric Dentistry Periodicity Guidelines (9 Pages) ........ CH-360
G.2 American Dental Association Guidelines for Prescribing Dental Radiographs
(3 Pages) ................................................................. CH-369
G.1 American Academy of Pediatric Dentistry Periodicity Guidelines (9 Pages)

Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents

Originating Committee
Clinical Affairs Committee

Review Council
Council on Clinical Affairs

Adopted
1991

Revised

Purpose
The American Academy of Pediatric Dentistry (AAPD) intends this guideline to help practitioners make clinical decisions concerning preventive oral health interventions, including anticipatory guidance and preventive counseling, for infants, children, and adolescents.

Methods
This guideline is a compilation of related policies and guidelines developed by the AAPD, in addition to pediatric oral health literature and national reports and recommendations. The related policies and guidelines provide additional references for individual recommendations.

Background
Professional care is necessary to maintain oral health. The AAPD emphasizes the importance of initiating professional oral health intervention in infancy and continuing through adolescence and beyond. The periodicity of professional oral health intervention and services is based on a patient's individual needs and risk indicators. Each age group has distinct developmental needs to be addressed at specific intervals as part of a comprehensive evaluation. Continuity of care is based on the assessed needs of the individual patient and assures appropriate management of all oral conditions, dental disease, and injuries. The early dental visit to establish a dental home provides a foundation upon which a lifetime of preventive education and oral health care can be built. Anticipatory guidance and counseling are essential components of the dental visit.

Recommendations
This guideline addresses periodicity and general principles of examination, preventive dental services, anticipatory guidance/counseling, and oral treatment for children who have no contributory medical conditions and are developing normally. An accurate, comprehensive, and up-to-date medical history is necessary for correct diagnosis and effective treatment planning. Recommendations may be modified to meet the unique requirements of patients with special needs.

Clinical oral examination
The first examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age. The developing dentition and occlusion should be monitored throughout eruption at regular clinical examinations. Unrecognized dental disease can result in exacerbated problems which lead to more extensive and expensive care whereas early detection and management of oral conditions can improve a child's oral health, general health and well-being, and school readiness. Early diagnosis of developing malocclusions may allow for timely therapeutic intervention.

Components of a comprehensive oral examination include assessment of:
- General health/growth
- Pain
- Extraoral soft tissue
- Temporomandibular joint
- Intraoral soft tissue
- Oral hygiene and periodontal health
- Intraoral hard tissue
- The developing occlusion
- Caries risk
- Behavior of child

Based upon the visual examination, the dentist may employ additional diagnostic aids (eg, radiographs, photographs, pulp testing, laboratory tests, study casts).

The most common interval of examination is 6 months; however, some patients may require examination and preventive

Copyright © American Association of Pediatric Dentistry. Reprinted by permission.
services at more frequent intervals, based on historical, clinical, and radiographic findings.\textsuperscript{5,23-34} Caries and its sequelae are among the most prevalent health problems facing infants, children, and adolescents in America.\textsuperscript{7} Caries is cumulative and progressive and, in the primary dentition, is highly predictive of caries occurring in the permanent dentition.\textsuperscript{35-36} Reevaluation and reinforcement of preventive activities contribute to improved instruction for the caregiver of the child or adolescent, continuity of evaluation of the patient’s health status, and repetitive exposure to dental procedures, potentially alleviating anxiety and fear for the apprehensive child or adolescent.

**Caries-risk assessment**

Risk assessment is the key element of contemporary preventive care for infants, children, adolescents, and persons with special health care needs. Its goal is to prevent disease by identifying and minimizing causative factors (e.g., microbial burden, dietary habits, plaque accumulation) and optimizing protective factors (e.g., fluoride exposure, oral hygiene, sealants).\textsuperscript{37} A caries-risk assessment tool (CAT) simplifies and clarifies the process.\textsuperscript{38} Sufficient evidence demonstrates certain groups of children at greater risk for development of early childhood caries (ECC) would benefit from infant oral health care.\textsuperscript{12,22,38-39} Infants and young children have unique caries-risk factors such as ongoing establishment of oral flora and host defense systems, susceptibility of newly erupted teeth, and development of dietary habits. Children are most likely to develop caries if mutans streptococci are acquired at an early age.\textsuperscript{39,40} The characteristics of ECC and the availability of preventive methods support anticipatory guidance/counseling as an important strategy in addressing this significant pediatric health problem. ECC can be a costly, devastating disease with lasting detrimental effects on the dentition and systemic health.\textsuperscript{13,19-27} Adolescence can be a time of heightened caries activity due to an increased intake of cariogenic substances and inattention to oral hygiene procedures.\textsuperscript{31,42} Risk assessment can assure preventive care is tailored to each individual’s needs and direct resources to those for whom preventive interventions provide the greatest benefit. Because a child’s risk for developing dental disease can change over time due to changes in habits (e.g., diet, home care), oral microflora, or physical condition, risk assessment must be repeated regularly and frequently to maximize effectiveness.

**Prophylaxis and topical fluoride treatment**

The interval for frequency of professional preventive services is based upon assessed risk for caries and periodontal disease. Gingivitis is nearly universal in children and adolescents\textsuperscript{41}; it usually responds to thorough removal of bacterial deposits and improved oral hygiene.\textsuperscript{43,44} Self-administered plaque control programs without periodic professional reinforcement are inconsistent in providing long-term inhibition of gingivitis.\textsuperscript{45} Many patients lack the skill or motivation to become and remain plaque-free for a significant time.\textsuperscript{44} Hormonal fluctuations, including those occurring during the onset of puberty, can modify the gingival inflammatory response to dental plaque.\textsuperscript{45} Children can develop any of the several forms of periodontitis, with aggressive periodontitis occurring more commonly in children and adolescents than adults.\textsuperscript{42}

Caries risk may change quickly during active dental eruption phases. Newly erupted teeth may be at higher risk of developing caries, especially during the post-eruption maturation process. Children who exhibit higher risk of developing caries would benefit from recall appointments at greater frequency than every 6 months. This allows increased professional fluoride therapy application, microbial monitoring, antimicrobial therapy reapplication, and reevaluating behavioral changes for effectiveness.\textsuperscript{34,47-48} An individualized preventive plan increases the probability of good oral health by demonstrating proper oral hygiene methods/techniques and removing plaque, stain, calculus, and the factors that influence their build-up.\textsuperscript{49-50}

Professional topical fluoride treatments should be based on caries risk assessment.\textsuperscript{33,43,45-53} A pumice prophylaxis is not an essential prerequisite to this treatment.\textsuperscript{34} Appropriate precautionary measures should be taken to prevent swallowing of any professionally-applied topical fluoride. Children at moderate caries risk should receive a professional fluoride treatment at least every 6 months; those with high caries risk should receive greater frequency of professional fluoride applications (e.g., every 3-6 months).\textsuperscript{72,53,57-62} Ideally, this would occur as part of a comprehensive preventive program in a dental home.\textsuperscript{11}

**Fluoride supplementation**

Fluoride contributes to the prevention, inhibition, and reversal of caries.\textsuperscript{50,62-72} The AAPD encourages optimal fluoride exposure for every child, recognizing fluoride in the community water supplies as the most beneficial and inexpensive preventive intervention. Fluoride supplementation should be considered when fluoride exposure is not optimal.\textsuperscript{50} Supplementation should be in accordance with the guidelines jointly recommended by the AAPD\textsuperscript{53}, the American Academy of Pediatrics\textsuperscript{45}, and the American Dental Association (ADA)\textsuperscript{49}, and endorsed by the Centers for Disease Control and Prevention.\textsuperscript{14}

**Anticipatory guidance/counseling**

Anticipatory guidance is the process of providing practical, developmentally-appropriate information about children’s health to prepare parents for the significant physical, emotional, and psychological milestones.\textsuperscript{59} Appropriate discussion and counseling should be an integral part of each visit. Topics to be included are oral hygiene and dietary habits, injury prevention, nonnutritive habits, substance abuse, intraoral/personal piercing, and speech/language development.

Oral hygiene counseling involves the parent and patient. Initially, oral hygiene is the responsibility of the parent. As the child develops, home care is performed jointly by parent and child. When a child demonstrates the understanding and ability to perform personal hygiene techniques, the health care professional should counsel the child. The effectiveness of home care should be monitored at every visit and includes a discussion on the consistency of daily preventive activities.\textsuperscript{73}
High-risk dietary practices appear to be established early, probably by 12 months of age, and are maintained throughout early childhood. Frequent bottle feeding at night, breastfeeding on demand, and extended and repetitive use of a no-spill training cup are associated with, but not consistently implicated in, ECC. The role of carbohydrates in caries initiation is unequivocal. Acids in carbonated beverages can have a deleterious effect (ie, erosion) on enamel. Excess consumption of carbohydrates, fats, and sodium contribute to poor systemic health. Dietary analysis and the role of dietary choices on oral health, malnutrition, and obesity should be addressed through nutritional and preventive oral health counseling at periodic visits. The US Department of Agriculture’s Food Pyramid and Center for Disease Control and Prevention/National Center for Health Statistics’ Growth Charts provide guidance for parents and their children and promote better understanding of the relationship between healthy diet and development.

Facial trauma that results in fractured, displaced, or lost teeth can have significant negative functional, aesthetic, and psychological effects on children. Practitioners should provide age-appropriate injury prevention counseling for orofacial trauma. Initially, discussions would include play objects, pacifiers, car seats, and electrical cords. As motor coordination develops, the parent/patient should be counseled on additional safety and preventive measures, including mouthguards for sporting activities. The greatest incidence of trauma to the primary dentition occurs at 2 to 3 years of age, a time of increased mobility and developing coordination. The most common injuries to permanent teeth occur secondary to falls, followed by traffic accidents, violence, and sports. Dental injuries could have improved outcomes if the public were aware of first-aid measures and the need to seek immediate treatment.

Nonnutritive oral habits (eg, digital and pacifier habits, bruxism, abnormal tongue thrusts) may apply forces to teeth and dentoalveolar structures. Although early use of pacifiers and digit sucking are considered normal, habits of sufficient frequency, intensity, and duration can contribute to deleterious changes in occlusion and facial development. It is important to discuss the need for early additional sucking, then the need to wean from the habits before malocclusion or skeletal dysplasias occur. Early dental visits provide an opportunity to encourage parents to help their children stop sucking habits by age 3 years or younger. For school-aged children and adolescent patients, counseling regarding any existing habits (eg, fingernail biting, clenching, bruxism) is appropriate.

Speech and language is an integral component of a child’s early development. Deficiencies and abnormal delays in speech and language production can be recognized early and referral made to address the concerns appropriately. Communication and coordination of appliance therapy with a speech and language professional can assist in the timely treatment of these disorders.

Smoking and smokeless tobacco use almost always are initiated and established in adolescence. During this time period, children may be exposed to opportunities to experiment with other substances that negatively impact their health and well-being. Practitioners should provide education regarding the serious health consequences of tobacco use and exposure to second hand smoke. The practitioner may need to obtain information regarding tobacco use and alcohol/drug abuse confidentially from an adolescent patient. When substance abuse has been identified, referral for appropriate intervention is indicated.

Complications from intraoral/perioral piercings can range from pain, infection, and tooth fracture to life-threatening conditions of bleeding, edema, and airway obstruction. Although piercings most commonly are observed in the teenaged pediatric dental patient, education regarding pathologic conditions and sequelae associated with these piercings should be initiated for the preteen child/parent and reinforced during subsequent periodic visits.

Radiographic assessment
Appropriate radiographs are a valuable adjunct in the oral health care of infants, children, and adolescents. Timing of initial radiographic examination should not be based upon the patient’s age. Rather, after review of an individual’s history and clinical findings, judicious determination of radiographic needs and examination can optimize patient care while minimizing radiation exposure. The US Food and Drug Administration/ADA guidelines were developed to assist the dentist in deciding under what circumstances specific radiographs are indicated.

Treatment of dental disease/injury
Healthcare providers who diagnose oral disease or trauma should either provide therapy or refer the patient to an appropriately trained individual for treatment. Immediate intervention is necessary to prevent further dental destruction, as well as more widespread health problems. Postponed treatment can result in exacerbated problems that may lead to the need for more extensive care. Early intervention could result in savings of health-care dollars for individuals, community health care programs, and third party payors.

Treatment of developing malocclusion
Guidance of eruption and development of the primary, mixed, and permanent dentitions is an integral component of comprehensive oral health care for all pediatric dental patients. Early diagnosis and successful treatment of developing malocclusions can have both short-term and long-term benefits, while achieving the goals of occlusal harmony and function and dentofacial esthetics. Early treatment is beneficial for many patients, but may not be indicated for every patient. When there is a reasonable indication that an oral habit will result in unfavorable sequelae in the developing permanent dentition, any treatment must be appropriate for the child’s development, comprehension, and ability to cooperate. Use of an appliance is indicated only when the child wants to stop the habit and would benefit from a reminder. At each stage of occlusal development, the objectives of intervention/treatment include: (1) reversing adverse growth;
(2) preventing dental and skeletal disharmonies; (3) improving esthetics of the smile; (4) improving self-image; and (5) improving the occlusion.29

Sealants
Sealants reduce the risk of pit and fissure caries in susceptible teeth and are cost-effective when maintained.30,31 They are indicated for primary and permanent teeth with pits and fissures that are predisposed to plaque retention. At-risk pits and fissures should be sealed as soon as possible. Because caries risk may increase at any time during a patient’s life due to changes in habits (eg, dietary, home care), oral microflora, or physical condition, unsealed teeth subsequently might benefit from sealant application.32 The need for sealant placement should be reassessed at periodic preventive care appointments. Sealants should be monitored and repaired or replaced as needed.

Third Molars
Panoramic or periapical radiographic assessment is indicated during late adolescence to assess the presence, position, and development of third molars.33-37 A decision to remove or retain third molars should be made before the middle of the third decade.38 Consideration should be given to removal when there is a high probability of disease or pathology and/or the risks associated with early removal are less than the risks of later removal.39

Referral for regular and periodic dental care
As adolescent patients approach the age of majority, it is important to educate the patient and parent on the value of transitioning to a dentist who is knowledgeable in adult oral health care. At the time agreed upon by the patient, parent, and pediatric dentist, the patient should be referred to a specific practitioner in an environment sensitive to the adolescent’s individual needs.40 Until the new dental home is established, the patient should maintain a relationship with the current care provider and have access to emergency services. Communication and records transfer allow for consistent and continuous care for the patient.

Recommendations by Age
6 to 12 months
1. Complete the clinical oral examination with adjunctive diagnostic tools (eg, radiographs as determined by child’s history, clinical findings, and susceptibility to oral disease) to assess oral growth and development, pathology, and/or injuries; provide diagnosis.
2. Provide oral hygiene counseling for parents, including the implications of the oral health of the caregiver.
3. Remove supragingival and subgingival stains or deposits as indicated.
4. Assess the child’s systemic and topical fluoride status (including type of infant formula used, if any, and exposure to fluoridated toothpaste) and provide counseling regarding fluoride. Prescribe systemic fluoride supplements, if indicated, following assessment of total fluoride intake from drinking water, diet, and oral hygiene products.
5. Assess appropriateness of feeding practices, including bottle and breast-feeding, and provide counseling as indicated.
6. Provide dietary counseling related to oral health.
7. Provide age-appropriate injury prevention counseling for orofacial trauma.
8. Provide counseling for nonnutritive oral habits (eg, digit, pacifiers).
9. Provide required treatment and/or appropriate referral for any oral diseases or injuries.
11. Consult with the child’s physician as needed.
13. Determine the interval for periodic reevaluation.

12 to 24 months
1. Repeat 6 to 12-month procedures every 6 months or as indicated by individual patient’s risk status/susceptibility to disease.
2. Assess appropriateness of feeding practices—including bottle, breast-feeding, and no-spill training cups—and provide counseling as indicated.
3. Review patient’s fluoride status—including any childcare arrangements which may impact systemic fluoride intake—and provide parental counseling.
4. Provide topical fluoride treatments every 6 months or as indicated by the individual patient’s needs.

2 to 6 years
1. Repeat 12- to 24-month procedures every 6 months or as indicated by individual patient’s risk status/susceptibility to disease. Provide age-appropriate oral hygiene instructions.
2. Scale and clean the teeth every 6 months or as indicated by individual patient’s needs.
3. Provide pit and fissure sealants for caries-susceptible primary molars and permanent molars, premolars, and anterior teeth.
4. Provide counseling and services (eg, mouthguards) as needed for orofacial trauma prevention.
5. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient’s needs.
6. Provide required treatment and/or appropriate referral for any oral diseases, habits, or injuries as indicated.
7. Assess speech and language development and provide appropriate referral as indicated.

6 to 12 years
1. Repeat 2- to 6-year procedures every 6 months or as indicated by individual patient’s risk status/susceptibility to disease.
2. Provide substance abuse counseling (eg, smoking, smokeless tobacco).
3. Provide counseling on intraoral/perioral piercing.
12 years and older
1. Repeat 6- to 12-year procedures every 6 months or as indicated by individual patient’s risk status/susceptibility to disease.
2. During late adolescence, assess the presence, position, and development of third molars, giving consideration to removal when there is a high probability of disease or pathology and/or the risks associated with early removal are less than the risks of later removal.
3. At an age determined by patient, parent and pediatric dentist, refer the patient to a general dentist for continuing oral care.

References


RECOMMENDATIONS FOR PEDIATRIC ORAL HEALTH ASSESSMENT, PREVENTIVE SERVICES, AND ANTICIPATORY GUIDANCE/COUNSELING

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references.

<table>
<thead>
<tr>
<th>American Academy of Pediatric Dentistry</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6 TO 12 MONTHS</td>
</tr>
<tr>
<td>Clinical oral examination</td>
<td>+</td>
</tr>
<tr>
<td>Assess oral growth and development</td>
<td>+</td>
</tr>
<tr>
<td>Caries-risk assessment</td>
<td>+</td>
</tr>
<tr>
<td>Radiographic assessment</td>
<td>+</td>
</tr>
<tr>
<td>Prophylaxis and topical fluorides</td>
<td>+</td>
</tr>
<tr>
<td>Fluoride supplementation</td>
<td>+</td>
</tr>
<tr>
<td>Anticipatory guidance/counseling</td>
<td>+</td>
</tr>
<tr>
<td>Oral hygiene counseling</td>
<td>+</td>
</tr>
<tr>
<td>Dietary counseling</td>
<td>+</td>
</tr>
<tr>
<td>Injury prevention counseling</td>
<td>+</td>
</tr>
<tr>
<td>Counseling for nonnutritive habits</td>
<td>+</td>
</tr>
<tr>
<td>Counseling for speech/language development</td>
<td>+</td>
</tr>
<tr>
<td>Substance abuse counseling</td>
<td>+</td>
</tr>
<tr>
<td>Counseling for intramural/perioral piercing</td>
<td>+</td>
</tr>
<tr>
<td>Assessment and treatment of developing malocclusion</td>
<td>+</td>
</tr>
<tr>
<td>Assessment for pit and fissure sealants</td>
<td>+</td>
</tr>
<tr>
<td>Assessment and/or removal of third molars</td>
<td>+</td>
</tr>
<tr>
<td>Transition to adult dental care</td>
<td>+</td>
</tr>
</tbody>
</table>

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child’s risk status/susceptibility to disease. Includes assessment of pathology and injuries.

2 By clinical examination.

3 Must be repeated regularly and frequently to maximize effectiveness.

4 Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease.

5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

6 Appropriate discussion and counseling should be an integral part of each visit for care.

7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

9 Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.

10 At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

11 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures, placed as soon as possible after eruption.

To view landscape and color version, see next page.
### Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text in the Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Infants, Children, and Adolescents (www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf) for supporting information and references.

#### Table: American Academy of Pediatric Dentistry

<table>
<thead>
<tr>
<th>Age</th>
<th>6 To 12 Months</th>
<th>12 To 24 Months</th>
<th>2 To 6 Years</th>
<th>6 To 12 Years</th>
<th>12 Years and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Oral Examination</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Assess Oral Growth and Development</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Caries-Risk Assessment</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Radiographic Assessment</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Prophylaxis and Topical Fluoride</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Fluoride Supplementation</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Anticipatory Guidance/Counseling</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Oral Hygiene Counseling</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Dietary Counseling</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Injury Prevention Counseling</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Counseling for Nonnutritive Habits</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Counseling for Speech/Language Development</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Substance Abuse Counseling</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Counseling for Intraosseous/Perioal Piercing</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Assessment and Treatment of Developing Malocclusion</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Assessment for Pit and Fissure Sealants</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Assessment and/or Removal of Third Molars</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td><strong>Transition to Adult Dental Care</strong></td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
</tbody>
</table>

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.
2. By clinical examination.
3. Must be repeated regularly and frequently to maximize effectiveness.
4. Timing, selection, and frequency determined by child's risk level, clinical findings, and susceptibility to oral disease.
5. Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.
6. Appropriate discussion and counseling should be an integral part of each visit for care.
7. Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.
8. At every appointment, initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
9. Initially play objects, pacifiers, car seats; when learning to walk, then with sports and routine playing, including the importance of mouthguards.
10. At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, bruxism, or chewing.
11. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.
G.2 American Dental Association Guidelines for Prescribing Dental Radiographs (3 Pages)

Guideline on Prescribing Dental Radiographs for Infants, Children, Adolescents, and Persons with Special Health Care Needs

Originating Committee
Ad Hoc Committee on Pediatric Dentistry

Review Council
Council on Clinical Affairs

Adopted
1981

Revised

Reaffirmed
1997

Purpose
The American Academy of Pediatric Dentistry (AAPD) intends this guideline to help practitioners make clinical decisions concerning appropriate selection of dental radiographs as part of an oral evaluation of infants, children, adolescents, and persons with special health care needs. The guideline can be used to optimize patient care, minimize radiation burden, and allocate health care resources responsibly.

Methods
The American Dental Association (ADA) initiated a review of The Selection of Patients for X-ray Examinations: Dental Radiographic Examinations in 2002. The AAPD, along with other dental specialty organizations, participated in the review and revision of these guidelines. The Food and Drug Administration (FDA) accepted them in November 2004. This review included a new systematic literature search of the MEDLINE/Pubmed electronic database using the following parameters: Terms: dental radiology, dental radiographs, dental radiography, cone beam computed tomography AND guidelines, recommendations; Fields: all fields; Limits: within the last 10 years, humans, and English. In 2006, the ADA Council on Scientific Affairs published an update to their recommendations for dental radiographs. The AAPD continues to endorse the ADA/FDA’s recommendations.

Background
Radiographs are valuable aids in the oral health care of infants, children, adolescents, and persons with special health care needs. They are used to diagnose oral diseases and to monitor dentofacial development and the progress of therapy. The recommendations in the ADA/FDA guidelines were developed to serve as an adjunct to the dentist’s professional judgment. The timing of the initial radiographic examination should not be based upon the patient’s age, but upon each child’s individual circumstances. Because each patient is unique, the need for dental radiographs can be determined only after reviewing the patient’s medical and dental histories, completing a clinical examination, and assessing the patient’s vulnerability to environmental factors that affect oral health.

Radiographs should be taken only when there is an expectation that the diagnostic yield will affect patient care. The AAPD recognizes that there may be clinical circumstances for which a radiograph is indicated, but a diagnostic image cannot be obtained. For example, the patient may be unable to cooperate or the dentist may have privileges in a health care facility lacking intraoral radiographic capabilities. If radiographs of diagnostic quality are unobtainable, the dentist should confer with the parent to determine appropriate management techniques (eg, preventive/restorative interventions, advanced behavior guidance modalities, deferral, referral), giving consideration to the relative risks and benefits of the various treatment options for the patient.

Because the effects of radiation exposure accumulate over time, every effort must be made to minimize the patient’s exposure. Good radiological practices (eg, use of lead apron, thyroid collars, and high-speed film; beam collimation) are important. The dentist must weigh the benefits of obtaining radiographs against the patient’s risk of exposure.

New imaging technologies [ie, cone beam computed tomography (CBCT)] have added 3-dimensional capabilities that have many applications in dentistry. Evidence-based guidelines and policies currently are under development by organizations such as the American Academy of Oral and...
<table>
<thead>
<tr>
<th>TYPE OF ENCOUNTER</th>
<th>Child with Primary Dentition (prior to eruption of first permanent tooth)</th>
<th>Child with Transitional Dentition (after eruption of first permanent tooth)</th>
<th>Adolescent with Permanent Dentition (prior to eruption of third molars)</th>
<th>Adult, Dentate or Partially Edentulous</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient* being evaluated for dental diseases and dental development</td>
<td>Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.</td>
<td>Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.</td>
<td>Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment.</td>
<td>Individualized radiographic exam, based on clinical signs and symptoms.</td>
</tr>
<tr>
<td>Recall patient* with clinical caries or at increased risk for caries**</td>
<td>Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe.</td>
<td>Posterior bitewing exam at 18-36 month intervals</td>
<td>Posterior bitewing exam at 24-36 month intervals</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Recall patient* with no clinical caries and not at increased risk for caries**</td>
<td>Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe.</td>
<td>Posterior bitewing exam at 18-36 month intervals</td>
<td>Posterior bitewing exam at 24-36 month intervals</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Recall patient* with periodontal disease</td>
<td>Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be identified clinically.</td>
<td>Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development. Panoramic or periapical exam to assess developing third molars</td>
<td>Usually not indicated</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Patient for monitoring of growth and development</td>
<td>Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development</td>
<td>Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development. Panoramic or periapical exam to assess developing third molars</td>
<td>Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development. Panoramic or periapical exam to assess developing third molars</td>
<td>Usually not indicated</td>
</tr>
<tr>
<td>Patient with other circumstances including, but not limited to, proposed or existing implants, pathology, restorative/endodontic needs, treated periodontal disease and caries remineralization</td>
<td>Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these circumstances.</td>
<td>Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these circumstances.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Clinical situations for which radiographs may be indicated include but are not limited to:

A. Positive Historical Findings
1. Previous periodontal or endodontic treatment
2. History of pain or trauma
3. Familial history of dental anomalies
4. Postoperative evaluation of healing
5. Remineralization monitoring
6. Presence of implants or evaluation for implant placement

B. Positive Clinical Signs/Symptoms
1. Clinical evidence of periodontal disease
2. Large or deep restorations
3. Deep carious lesions
4. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of dental/facial trauma
7. Mobility of teeth
8. Sinus tract (*“fistula”)

9. Clinically suspected sinus pathology
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects
14. Pain and/or dysfunction of the temporomandibular joint
15. Facial asymmetry
16. Abnormal teeth for fixed or removable partial prosthesis
17. Unexplained bleeding
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or color
21. Unexplained absence of teeth
22. Clinical erosion

**Factors increasing risk for caries may include but are not limited to:
1. High level of caries experience or demineralization
2. History of recurrent caries
3. High titers of cariogenic bacteria
4. Existing restoration(s) of poor quality
5. Poor oral hygiene
6. Inadequate fluoride exposure
7. Prolonged nursing (bottle or breast)
8. Frequent high sucrose content in diet
9. Poor family dental health
10. Developmental or acquired enamel defects
11. Developmental or acquired disability
12. Xerostomia
13. Genetic abnormality of teeth
14. Many multisurface restorations
15. Chemoradiation therapy
16. Eating disorders
17. Drug/alcohol abuse
18. Irregular dental care

Maxillofacial Radiology (AAOMR). The usefulness and future of CBCT have been reviewed with an introduction to issues related to criteria, ramifications, and medico-legal considerations. Certain principles clearly are emerging and point to the need for standards of provisions of care. Because this technology has potential to produce vast amounts of data and imaging information beyond initial intentions, it is important to interpret all information obtained, including that which may be beyond the immediate diagnostic needs of the practitioner.

Recommendations
The recommendations of the ADA/FDA guidelines are contained within the accompanying table. "The recommendations in this chart are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient’s health history and completing a clinical examination. Because every precaution should be taken to minimize radiation exposure, protective thyroid collars and aprons should be used whenever possible. This practice is strongly recommended for children, women of childbearing age, and pregnant women."  

Although standards are not officially developed for the use of CBCT, this advance in orofacial dental imaging is an excellent adjunct for improvements in dental care. The executive opinion statement of the AAOMR provides initial guidance for the use of this technology. Their recommendations relate to the need for practices of qualified individuals to use this technology with selection criteria which include clear indications that minimize radiation exposure while maximizing diagnostic information obtained. When using CBCT, the resulting imaging is required to be supplemented with a written report placed in the patient’s records that includes full interpretation of the findings.

References