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3.1 Client Benefits

Benefits of the CSHCN Services Program processed by TMHP include, but are not limited to, the following services:

- Ambulance
- Ambulatory or day surgery
- Augmentative communication devices (ACDs)
- Behavioral health
- Stem cell transplants
- Charges related to the transportation of deceased clients
- Dental and orthodontia
- Drug copayments (except Children’s Health Insurance Program [CHIP] drug copayments)
- Durable medical equipment and expendable medical supplies
- Eye prostheses
- Gastrostomy devices
- Genetic services
- Hearing services
- Hemophilia blood factor products (pharmacy providers)
- Home health services
- Hospice services
- Independent laboratory services
- Inpatient hospital services
- Inpatient hospital rehabilitation services
- Insurance Premium Payment Assistance (IPPA) Program reimbursements
- Medical foods
- Medical nutritional services and products, and total parenteral nutrition (TPN) services
- Orthotics and prosthetics
- Outpatient hospital services
- Outpatient physical and occupational therapy
- Outpatient speech-language pathology
- Physical medicine and rehabilitation
- Physician services, including physician services performed by advanced practice registered nurses (APRNs) and telemedicine services
- Podiatry
- Prescription shoes
- Radiology and radiation therapy services
- Renal dialysis
- Renal transplants
- Respiratory care and equipment
- Sleep studies
- Telemedicine
- Vision care
3.1.1 Hearing Aid Benefits Now Administered by TMHP
The CSHCN Services Program may reimburse appropriately-enrolled providers for audiometry and other hearing services.

The Program for Amplification for Children of Texas (PACT) has been discontinued and TMHP has assumed the administration of hearing services for clients who are birth through 20 years of age under the current hearing services benefit, which now includes clients of all ages.

Authorization is not required for hearing services provided by physicians.

Refer to: Chapter 19, “Hearing Services” on page 19-1 for additional information regarding these services.

3.1.2 Prescription Benefits Processed by the Texas Medicaid/ CHIP Vendor Drug Program (VDP)
The VDP processes all prescription drug claims for CSHCN Services Program eligible clients. Claims for the following drugs and products can be submitted for reimbursement:

- Aerosolized tobramycin (TOBI)*
- Growth hormone products*
- Human immunodeficiency virus (HIV)/ acquired immunodeficiency syndrome (AIDS) drugs*
- Insulin/insulin syringes
- Medications for home use (including vitamins)
- Pulmozyme*

*Prior authorization is required for these drugs. Requests for prior authorization are submitted to the VDP. To contact the VDP, call 1-800-435-4165 or go to the following website: www.hhsc.state.tx.us/HCF/vdp/vdpstart.html.

An approved prescribing physician must submit a completed and signed Pulmozyme and TOBI Medical Information Form annually certifying that the client continues to require these medications.

Note: Qualifying HIV/AIDS drugs may be considered for reimbursement under the VDP for clients covered by third-party insurance. A denial from the Texas HIV Medicaid program and the third-party payer must be submitted.

3.1.3 Services Provided by the Medical Transportation Program (MTP)
The MTP makes travel arrangements for CSHCN Services Program clients. Clients must call MTP to request travel assistance. To contact MTP, call 1-877-633-8747.

3.1.4 Services Provided Outside of Texas
For CSHCN Services Program reimbursement for providers outside of Texas, all CSHCN Services Program policies and procedures apply, including the requirement that providers of services covered by Medicaid be enrolled and remain enrolled as Title XIX Medicaid providers.

3.1.4.1 Fifty or Fewer Miles From the Texas State Border
For clients who would otherwise experience financial hardship or be subject to clear medical risk, the CSHCN Services Program may cover services that are within the scope of the program, provided by health-care providers in Arkansas, Louisiana, New Mexico, or Oklahoma, and located within 50 or fewer miles from the Texas state border.
3.1.4.2 More Than Fifty Miles From the Texas State Border

Requests for medical services provided by an out-of-state provider must be submitted to the CSHCN Services Program for consideration.

The CSHCN Services Program may approve coverage of services that are within the scope of the CSHCN Services Program, provided by health-care providers located within the United States, and more than 50 miles from the Texas border. The CSHCN Services Program participating physician, client, parent or guardian, and CSHCN Services Program medical director may agree in unique circumstances that:

• An out-of-state provider is the provider of choice for quality care.
• The same treatment or another treatment of equal benefit or cost is not available from Texas CSHCN Services Program providers.
• The out-of-state treatment should result in a decrease in the total projected CSHCN Services Program cost of the client’s treatment.
• Medical literature indicates that the out-of-state treatment is accepted medical practice and is expected to improve the client’s quality of life.

The limitations listed above do not apply to coverage for or payment to CSHCN Services Program providers of selected products or devices such as medical foods or hearing amplification devices, which are always less costly or are only available from out-of-state sources.

Inpatient and outpatient reimbursement rates for providers located more than 50 miles from the Texas state border are negotiated. Physicians may be reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM), unless the procedure is normally priced by another methodology. The CSHCN Services Program may cover the costs of transportation and associated meals and lodging for a client and, if necessary, a responsible adult for travel to and from the location of out-of-state services that meet program approval. Travel costs are negotiated, and the approval of specific travel options is based on overall cost-effectiveness.

The provider must enroll in the CSHCN Services Program to be reimbursed. Specialty team or center requirements do not apply. Filing deadlines apply, but routine authorization requirements and procedures do not apply, as special, advance approval must be given by the CSHCN Services Program.

Enrollment applies only to the services approved for an individual client. After the approved claims are processed for the out-of-state services, the provider’s enrollment and identifying numbers are discontinued. No additional services are paid.

For more information, contact the CSHCN Services Program by telephone at 1-800-252-8023 or by mail at:

CSHCN Services Program
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347

3.1.5 CSHCN Services Program Services and Supplies Limitations and Exclusions

The following services and supplies are not CSHCN Services Program benefits (this list is not all-inclusive):

• Abortions
• Allergy treatment services, except antibiotic desensitization
• Autopsies
• Care and treatment related to any condition for which benefits are provided or available under worker’s compensation laws
• Chiropractic treatment
• Custodial care
• Donor search for kidney transplants
• Donor search for stem cell transplants
• Fertility services
• Fetal medical and surgical services
• Inpatient hospital tests not specifically ordered by the physician responsible for the diagnosis or treatment of the client’s condition
• Intestinal bypass surgery and gastric stapling for the treatment of morbid obesity
• More than 60 days of inpatient hospitalization per calendar year
  Note: An additional 60-day hospital stay begins on the date of hospital admission for an approved stem cell transplant.
• More than 90 days of inpatient rehabilitation per calendar year
• Portable X-ray services
• Procedures and services that are considered experimental or investigational
• Recreational therapy
• Routine newborn services
• Separate fees for completing or filing a CSHCN Services Program claim form, CSHCN Services Program Physician/Dentist Assessment Form (PAF), or other documentation
• Services or supplies for which benefits are available under any other contract, policy, or insurance
• Services or supplies for which claims were not submitted within the filing deadline
• Services or supplies not reasonable and necessary for diagnosis or treatment
• Services or supplies not specifically a benefit of the CSHCN Services Program
• Services or supplies provided before the eligibility effective date of the designation by the CSHCN Services Program as a client, or after the effective date of the denial of eligibility
• Services or supplies provided to clients on the CSHCN Services Program waiting list, unless authorized by the CSHCN Services Program to determine urgency of need for program eligibility purposes
• Services or supplies provided to a client after a finding was made during utilization review procedures that indicates these services or supplies are not medically necessary
• Services payable by any health, accident, or other insurance coverage; by any private or other governmental benefit system; or by any legally liable third party
• Services provided by ineligible, suspended, or excluded providers
• Social and educational counseling
• Solid organ transplants and related services (liver, lung, heart, and pancreas)
• Sterilizations, infertility, obstetrics, and family-planning services
• Substance abuse treatment
• Telephone calls, computer calculations, reports, and medical testimony

3.1.6 CSHCN Services Program Procedure Limitations and Exclusions
The following procedures are not a benefit (this list is not all-inclusive):
• Ambulatory blood pressure monitoring
• Augmentation mammoplasty or breast reconstruction (except following a medically necessary mastectomy)
• Biofeedback therapy
• Cardiokymography
• Cellular therapy
• Chemolase injection (chymodiactin and chymopapain)
• Chemonucleolysis intervertebral disc
• Circumcisions (routine)
• Color vision and dark adaption exams
• Continuous tissue temperature monitoring
• Craniotomy for lobotomy
Chapter 3

- Dermabrasion/chemical peel
- Dressings/supplies billed in physician's office
- Ear piercing or repair
- Ear protector attenuation measurements
- Ergonovine provocation test
- Extracorporeal membrane oxygenation (ECMO)
- Extracorporeal photopheresis
- Fabric wrapping of abdominal aneurysms
- Hair analysis, treatment, and electrolysis
- Hyperthermia and hypothermia
- Implantation of antiesophageal reflux device
- Intermittent positive pressure breathing (IPPB) (physician services)
- Intersex surgery (except to repair/treat congenital defects)
- Intra-aortic balloon counterpulsation (monitoring or supervision of pump technician)
- Lipectomies and rhytidectomies
- Manipulation of chest wall, including percussion
- Master's electrocardiogram (ECG)
- Magnetic resonance imaging (MRI) of myocardium
- Nail bed reconstruction
- Nipple exploration or reconstruction and related services (except following a medically necessary mastectomy)
- Obsolete diagnostic tests
- Obstetrical tests
- Orthomolecular therapy
- Outpatient cardiac rehabilitation
- Penile plethysmography or nocturnal tumescence test
- Peripheral and thermal angioplasty
- Peyronie disease treatment
- Phlebotomy, therapeutic
- Photokymography
- Prolonged extracorporeal circulation
- Prolotherapy
- Prostate treatment (massage and surgery)
- Quest test (infertility)
- Routine blood drawing for specimens
- Salivary gland and duct diversion/ligation
- Sclerosing solution injections for telangiectasia
- Silicone/collagen injections (cosmetic)
- Single photon emission computerized tomography (SPECT) imaging
- Speech prosthesis insertion
- Sterilization reversal
- Tattooing
- Thermogram (lumbar and cervical)
- Transfer factor
- Travel allowance for specimen collection for homebound clients
3.2 Client Eligibility

3.2.1 Financial Eligibility Criteria

Applicants who are 18 years of age or younger and are applying or reapplying for the CSHCN Services Program must also apply to Medicaid, to the Medically Needy Program (MNP), and to CHIP. A written Medicaid and CHIP determination must be sent with the application for the CSHCN Services Program. Applicants who are not citizens or legal residents of the United States or who are currently enrolled in CHIP or Texas Medicaid are exempt from this requirement.

If the CSHCN Services Program does not receive the Medicaid or CHIP determination or evidence of exemption from this requirement with the application, the applicant is given 60 days to submit the requested information. During this 60-day period, the applicant may send in any additional information that the CSHCN Services Program requires to process the application. If all information is received before the 60 days end, the CSHCN Services Program may grant eligibility for CSHCN Services Program health-care benefits or place the client on the waiting list with an eligibility date retroactive 15 days from the day on which the application was received.

When the client or applicant has all the documentation required to approve his or her case for CSHCN Services Program health-care benefits except for the Medicaid and CHIP determinations, the program may approve the case for 60 days until the Medicaid and CHIP determinations are received. Services are suspended if the Medicaid or CHIP determinations are not received on or before the 60 days end. The suspension remains until the requested information is received. Once all of the requested information is received, eligibility is granted. Eligibility is suspended between the 60-day cutoff date and the date on which the requested information is received.

An extension of 30 days may be granted for exceptional circumstances when requested.

The CSHCN Services Program does not pay for any services until the client’s application is approved and the client is eligible to receive CSHCN Services Program health-care benefits.

Any questions concerning a client’s eligibility for benefits of the CSHCN Services Program must be directed to the CSHCN Services Program Central Office at 1-800-252-8023.

A person may be eligible for health-care benefits under the CSHCN Services Program if the following conditions are met:

• The applicant lives in Texas and is a bona fide resident who, if a minor child, is also the dependent of a bona fide Texas resident. A bona fide resident physically lives in Texas, intends to remain in Texas permanently or indefinitely, maintains living quarters in Texas, does not claim to be a resident of another state or country, and has not come to Texas from another country for the purpose of obtaining medical care.

• The applicant is 20 years of age or younger. Persons diagnosed with cystic fibrosis are exempt from this requirement.

• The applicant’s family meets the CSHCN Services Program financial eligibility criteria.

• The applicant’s physician or dentist attests to the program’s Medical Certification Definition and provides a diagnosis that meets the definition on the CSHCN Services Program PAF located in the CSHCN Services Program Application Booklet.

The applicant must be eligible for medical assistance at the time the service is provided. Having an application for CSHCN Services Program eligibility in process is not a guarantee that the applicant can become eligible. Services and supplies are not paid by the CSHCN Services Program if they are provided to a client before the effective date of his or her eligibility or after the effective date of his or her denial of eligibility.

Note: It is important that all client eligibility information be kept up to date. CSHCN Services Program financial eligibility must be updated every 6 months. Medical eligibility must be updated annually; however, medical information may be updated at any time there is a change in the client’s condition.
3.2.2 CSHCN Services Program PAF/ Medical Eligibility Criteria

An important element of determining client eligibility is the CSHCN Services Program Physician Assessment Form (PAF). The PAF provides the CSHCN Services Program with vital information about the client's medical condition, qualifies the client as medically eligible for the program, and is used when clients are considered for removal from the waiting list. Copies of the form are included with the application packet, and clients or their families must ensure that a physician or dentist provides the information to meet the medical eligibility requirements of the CSHCN Services Program. The PAF must be updated at least annually, but may be updated whenever a client's medical condition changes. It is important that all client eligibility information be as current as possible.

Instructions for updating the PAF are provided in Appendix B, “CSHCN Services Program Instructions for Physician/Dentist Assessment Form,” on page B-110 and a sample of the “CSHCN Services Program Physician/Dentist Assessment Form” is shown on page B-112.

Tip: Providers can photocopy this form from the manual, but should retain the original for future use. The instructions and CSHCN Services Program PAF are also available on the TMHP website.

To be deemed valid, the CSHCN Services Program PAF must be completed properly, and the client must have been seen by a physician or dentist within the past 12 months. If YES is noted in the Determination of Urgent Need for Services section, an explanation must be entered to justify the YES answer. A physician or dentist must complete the Physician/Dentist Data section of the form, sign it, and date it. The signature must be an original signature. Stamped signatures are not accepted. The form can only be signed by a physician (doctor of medicine [MD], doctor of osteopathy [DO], doctor of dental surgery [DDS], or doctor of dental medicine [DMD]).

The CSHCN Services Program is not diagnosis-restricted; however, a valid International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code that indicates an applicant’s chronic physical condition is required on the PAF. This information is important for program data purposes and to ensure that the applicant meets the program’s definition of a child with special health-care needs. The primary diagnosis on the PAF must be medical in nature and an ICD-9-CM diagnosis code that meets the program’s criteria. Any additional diagnoses may be listed in the Other Diagnoses and Conditions section located below the Primary Diagnosis line.

The CSHCN Services Program rules state that the following medical criteria should be used when referring clients to the program: “A chronic developmental condition must include physical manifestations and may not be solely a delay in intellectual, mental, behavioral, or emotional development.” Similarly, the rules state the following for a chronic physical condition: “Such a condition may exist with accompanying developmental, mental, behavioral, or emotional conditions, but is not solely a delay in intellectual development or solely a mental, behavioral, or emotional condition.”

A diagnosis of mental retardation, autism, or attention deficit hyperactivity disorder (ADHD) does not indicate a physical disability by itself. If the client also has cerebral palsy or another condition causing physical disability, use that diagnosis on the PAF to expedite the processing of the application.

3.3 CSHCN Services Program Eligibility Form

The CSHCN Services Program Eligibility Form gives clients, parents, and providers a quick way to verify CSHCN Services Program eligibility. The form is designed to convey all of the information necessary to document identification information, Medicaid or other insurance information (including CHIP) listed on the form at the time of application is valid and must be verified independently.

CSHCN Services Program Eligibility Forms are valid for a 6-month coverage period. Clients must reapply for CSHCN Services Program health-care benefits every 6 months. A new application and all proofs of financial eligibility must be submitted each time a client reapplies for the CSHCN Services Program.

The CSHCN Services Program Eligibility Form provides the reapplication deadlines specific to each client. It tells clients the earliest day that they can start the reapplication and lets them know that they must submit a renewal application before their eligibility ends.

Refer to: Section 3.3.2, “CSHCN Services Program Eligibility Form Sample,” on page 3-10.

Approximately 60 days before the eligibility renewal date, the CSHCN Services Program mails a letter and a reapplication packet containing the CSHCN Services Program Application Booklet (T-3) to clients and their families. If a client or family has not received the packet within 30 days prior to their renewal date, they should obtain a copy of the CSHCN Services Program Application Booklet, either by requesting one from their local CSHCN Services Program Regional Office (refer to the listing at
Section 1.2.2, “Regional Offices,” on page 1-5 of this manual, by calling the CSHCN Services Program Central Office at 1-800-252-8023, or by downloading the booklet from the CSHCN Services Program website at www.dshs.state.tx.us/cshcn/clapplforms.shtm.

The CSHCN Services Program Eligibility Form gives eligibility information. Providers should ask for the form when scheduling a client for an appointment. Under certain circumstances, the form may not be valid at the time the provider sees the client. Providers should verify client eligibility before providing services by using the following options:

- CSHCN Services Program Automated Inquiry System (AIS) at 1-800-568-2413
- CSHCN Services Program at 1-800-252-8023
- TMHP Electronic Data Interchange (EDI) Gateway
- TMHP website at www.tmhp.com

If the client is not eligible when they arrive for an appointment, the provider must advise the client that they are being accepted as a private-pay client at the time the service is provided. The client will be responsible for paying for all services received. Providers are encouraged to ensure that the client signs written notification indicating that the client is being accepted as a private-pay client.

3.3.1 Case Restrictions

Restrictions are added to client case records for the following reasons:

- The CSHCN Services Program needs a Medicaid or CHIP determination.
- The client or family has moved.
- The family circumstances have changed, possibly making the client ineligible for the CSHCN Services Program.
- The client or family must apply to the Medically Needy Program.

The restriction period usually lasts 60 days. A 30-day extension may be granted when requested.

The client can continue to receive CSHCN Service Program benefits while there is a pending restriction on the case. However, there are a few important conditions to keep in mind.

- If the requested information or documentation is received before the end of the restriction period, the restriction is closed. There will be no lapse in the client’s CSHCN Services Program financial eligibility or coverage for health benefits.
- If the information or documentation is received after the end of the restriction period (and the added 30-day extension, if requested), but before the end of the client’s financial eligibility, there will be a lapse in coverage for health benefits. Coverage for health benefits resumes as soon as the information is received.
- If the information is received after the client’s financial eligibility expires, the client’s name is placed on the CSHCN Services Program’s waiting list. The client is no longer eligible for health benefits.

A waiting list client who has a restriction cannot be removed from the list until the requested information or documentation is received.

Refer to: Section 3.4, “Waiting List Information,” on page 3-11.
3.3.2 CSHCN Services Program Eligibility Form Sample

This form may be used for services only between the “valid” dates listed in the box above.

This is your NEW CSHCN Services Program Eligibility Form. If you already have a form, throw away the old one. Take this form with you when you visit CSHCN Services Program providers. Do not loan this form to other people. Service providers can copy the form for their files. If you lose this form, call the CSHCN Services Program Eligibility Section. Whenever you call or write to the CSHCN Services Program, use the case number (Case #) shown on this form.

You must reapply for the CSHCN Services Program every 6 months. Send a new application and all proofs each time you reapply for CSHCN Services Program financial eligibility.

To stay on the CSHCN Services Program after this form runs out you must fill out a new CSHCN Services Program application and send the application to the CSHCN Services Program on or after xx/22/xxx. However, your application must be received by the CSHCN Services Program not later than xx/03/2xxx. To get a new CSHCN Services Program application, call the CSHCN Services Program at 1-800-252-8023.

Este formulario se puede usar para conseguir servicios solamente durante las fechas válidas (valid) indicadas en la casilla de arriba.

Éste es su NUEVO formulario de elegibilidad para el Programa de Servicios de CSHCN. Si usted ya tiene un formulario, tire el formulario viejo. Lleve este formulario consigo para obtener servicios de los proveedores del Programa de Servicios de CSHCN. No preste este formulario a otras personas. Los proveedores pueden hacer una copia de este formulario para sus archivos. Si usted pierde este formulario, llame al personal de la Sección de Elegibilidad del Programa de Servicios de CSHCN. Siempre y cuando usted llame o escriba al Programa de Servicios de CSHCN, use el número de caso (Case #) que aparece en este formulario.

Usted tiene que presentar una nueva solicitud para el Programa de Servicios de CSHCN cada 6 meses. Mande una nueva solicitud y todos los comprobantes cada vez que usted presente una solicitud para elegibilidad financiera al Programa de Servicios de CSHCN.

Para continuar en el Programa de Servicios de CSHCN después de que termine su elegibilidad, tiene que rellenar una nueva solicitud del Programa de Servicios de CSHCN y mandar la solicitud al Programa de Servicios de CSHCN después del xx/22/xxx. Sin embargo, el Programa de Servicios de CSHCN tiene que recibir su solicitud al más tardar el xx/03/2xxx. Para obtener una nueva solicitud para el Programa de Servicios de CSHCN, llame al Programa de Servicios de CSHCN al número 1-800-252-8023.

Provider Information

The client named on this form is eligible for CSHCN Services Program benefits for the period indicated. Service providers may duplicate this form for their files. Providers must be enrolled in the CSHCN Services Program. Prior authorization is required for some services. The CSHCN Services Program may revoke eligibility in the event of policy changes, changes in client medical or financial condition, or error. See the CSHCN Services Program Provider Manual for details. For more information, contact the CSHCN Services Program.

Under certain circumstances, the eligibility form MAY NOT be valid at the time you see this client. Please verify client’s eligibility for CSHCN Services Program Benefits by calling CSHCN-AIS at 1-800-568-2413 or the TMHP-CSHCN Contact Center at 1-800-568-2413.
3.4 Waiting List Information

The CSHCN Services Program may establish a waiting list when budgetary limitations exist. Clients may be placed on the waiting list based on the date and time their application or reapplication is processed and approved for CSHCN Services Program. Clients are removed from the list when funds become available.

The waiting list is maintained continually from one fiscal year to the next. Clients must maintain program eligibility to remain on the waiting list. A lapse of program eligibility changes a client’s placement on the health-care benefits waiting list.

Clients placed on the waiting list are notified of their status. The CSHCN Services Program contacts waiting list clients periodically to confirm their eligibility for CSHCN Services Program services.

Clients on the waiting list do not receive a CSHCN Services Program Eligibility Form. The CSHCN Services Program sends information on the waiting list process to adult clients, the parent, guardian, caretaker, or managing conservator of a minor child, the DSHS Regional Office, and the client’s physician or dentist. Applicants are not placed on the waiting list until it is determined that they meet all eligibility criteria for the program.

If all of the documentation necessary to complete the application has been received except the Medicaid or CHIP determinations, the client is placed on the waiting list. The Medicaid or CHIP determinations must be received before the client may be removed from the waiting list.

Waiting list clients who wish to remain eligible to be considered for program health-care benefits must reapply for eligibility before their eligibility is scheduled to end. The eligibility coverage period is 6 months (i.e., 183 days from the first day of the client’s current eligibility period). Clients are notified of program deadlines to re-establish eligibility. Within 60 days of the client’s eligibility end date, the CSHCN Services Program mails the client a CSHCN Services Program application booklet and a letter advising that it is time to reapply.

If an application is submitted without all of the required documentation, the application is considered incomplete, and the applicant or client is allowed 60 days to complete it. If the reapplication process is not complete within the 60-day period, the client’s place on the waiting list is forfeited. When the CSHCN Services Program receives a completed reapplication after the 60-day period, the client is placed at the end of the waiting list according to the approval date of his or her complete application.

Note: When the CSHCN Services Program has a waiting list, applicants may not receive diagnosis and evaluation services to determine program medical eligibility. Diagnosis and evaluation services may be authorized only if needed to determine whether an applicant has an urgent need for health-care benefits.

As CSHCN Services Program funds become available, clients may be removed from the waiting list. Funding decisions concerning the waiting list are based both on the amount of program funds available and the anticipated amounts required to provide health-care benefits. The order in which clients are removed is not purely sequential; it depends on a combination of factors, including the urgent medical need of the condition as reported by a physician or dentist on the CSHCN Services Program PAF, the availability of other health insurance, the client’s age, and the date and time of the latest uninterrupted eligibility period.

When a client is removed from the waiting list, the client receives a new program approval letter and a CSHCN Services Program Eligibility Form with the active eligibility dates and information regarding the range of services. While financial eligibility must be renewed every 6 months, medical eligibility is valid for 12 months. If, however, there is a change in the client’s condition, medical information may and should be updated at any time. It is important that all client eligibility information is current at all times.

3.5 Clients Eligible for CHIP and CSHCN Services Program Benefits

CHIP offers comprehensive health-care coverage to thousands of Texas children who are uninsured. CHIP provides services such as physician care, medications, medical equipment, therapies, hospitalization, and much more.

Many children in the CSHCN Services Program are eligible for CHIP. Children may receive CHIP and CSHCN Services Program benefits at the same time. The CSHCN Services Program may pay for meals, transportation, lodging, other services not available from CHIP, or services beyond the CHIP maximum benefit. The CSHCN Services Program is the payer of last resort for medical services.
CHIP benefits apply to all children in the family, including the child who also is eligible for the CSHCN Services Program. For more information about CHIP, (children and perinatal coverage), contact CHIP/Children’s Medicaid at 1-877-KIDS-NOW (1-877-543-7669) or visit the CHIP website at www.chipmedicaid.com.

3.6 Clients Eligible for Medicaid and CSHCN Services Program Benefits

If the Medicaid claims administrator (TMHP) denies a claim with the explanation of benefits (EOB) code 00182 (client not eligible), but the family has evidence that the client is eligible for Medicaid, providers must appeal or resubmit the claim to TMHP. Client Medicaid eligibility information may not have been available at the time of the first claim submission.

The Medicaid Texas Health Steps-Comprehensive Care Program (THSteps-CCP) and Texas Medicaid (Title XIX) Home Health Services cover medically necessary services for enrolled clients who are 20 years of age or younger. The CSHCN Services Program does not consider reimbursement for services provided to children who are also eligible for Medicaid, with the exception of the transportation of a deceased client’s body.

The CSHCN Services Program does not pay claims for clients eligible for Medicaid THSteps-CCP that are denied by Medicaid for any reason, including late filing, limited client, duplicate services, incorrect claim form, or additional information required.

For additional information about Medicaid THSteps-CCP, call 1-800-846-7470, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time.

Information about Medicaid is printed on the CSHCN Services Program Eligibility Form. The coverage is indicated by the word Medicaid, below the date of birth in the CSHCN Services Program Client Number block. This information is obtained at the time of application, and it must be verified at the time the service is provided.

If Medicaid pays benefits that also were paid by the CSHCN Services Program, the full CSHCN Services Program payment must be refunded. Providers must make the refund check payable to TMHP and send it to the attention of the TMHP Financial Unit. The refund check must be accompanied by a “CSHCN Services Program Refund Information Form,” which is found on page B-134, to the following address:

Texas Medicaid & Healthcare Partnership
Attn: Financial Unit
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

The following information must be included:

• Client name and CSHCN Services Program client number
• Copies of the Remittance and Status (R&S) Reports from both Texas Medicaid and the CSHCN Services Program that show the claims were paid
• Date of service
• Provider name
• Provider identifiers

3.6.1 Medically Needy Program (MNP)

The MNP provides access to Medicaid benefits for children who are 18 years of age or younger and whose family income exceeds the eligibility limits under Temporary Assistance to Needy Families (TANF) or one of the medical-assistance-only programs for children, but whose income and assets are not sufficient to meet their medical expenses.

The CSHCN Services Program requires all applicants to include a Medicaid determination or exemption along with their application. No services are paid by the CSHCN Services Program until Medicaid eligibility is determined.
The CSHCN Services Program may ask clients to apply to the MNP if $2,000 or more in medical bills were paid or are expected to be paid by the CSHCN Services Program. Clients are given 60 days to apply to the MNP and send the determination to the CSHCN Services Program. A client’s CSHCN Services Program eligibility is suspended if he or she does not comply with the request to apply to MNP. CSHCN Services Program client benefits are not limited during this 60-day period.

3.6.2  MNP Spend Down Processing

The MNP is not an assistance program in itself, but it provides a way to access Medicaid benefits. The applicant must meet the basic TANF eligibility requirements. Eligibility may be determined with or without spend down (the difference between the applicant’s net income and the MNP income limits). When the applicant is eligible without spend down (income is below MNP income limits), the applicant is certified to be Medicaid-eligible. When spend down is required, the spend down amount must be met to obtain Medicaid coverage.

When spend down is applicable, the client is issued a Medical Bills Transmittal (Form H1120 or H1122) that indicates the spend down amount and the months of potential coverage (limited to the month of application and any of the 3 months before the application month). All medical bills (for all family members) must be submitted to the TMHP-Medically Needy Clearinghouse (MNC), along with the Form H1120 or H1122 for application toward the spend down amount.

Texas Medicaid & Healthcare Partnership
Medically Needy Clearinghouse
PO Box 202947
Austin, TX 78720-2947

Charges from the bills are applied in date-of-service order to the spend down amount. The spend down is met when the accumulated charges equal the spend down amount.

Note: Providers must include the CSHCN Services Program client number and the CSHCN Services Program client name on all of the documentation sent to the CSHCN Services Program or the TMHP-MNC.

3.6.2.1  CSHCN Services Program and MNP Spend Down Processing

The CSHCN Services Program can assist with the submission of medical bills to apply for Medicaid coverage through the spend down process. TMHP-MNC accepts paid or unpaid medical bills from the CSHCN Services Program for application toward the spend down amount regardless of the date of service. This process enables the TMHP-MNC to expedite the conclusion of the case and inform DSHS when the spend down is met.

When the spend down is met and the client is certified as Medicaid-eligible, the CSHCN Services Program may consider whether any of the services used to meet the spend down amount (client liability) may be considered for CSHCN Services Program health-care benefits coverage.

3.6.2.2  Provider Assistance to Clients with Spend Down

Providers may assist clients by:

• Submitting bills to TMHP-MNC for the CSHCN Services Program client that are not payable by the program.
• Submitting bills to TMHP-MNC for services provided to any other member of the family.
• Providing clients and families with current itemized statements.
• Encouraging clients to submit all of the medical bills they incurred from all of their providers.

Submitted bills must be itemized and must show the provider’s name, client’s name, CSHCN Services Program client number, MNP client number, dates of service, services provided, charge for each service, total charges, amounts of payments, dates of payments, and total due.

Bills for past accounts must be current itemized statements (dated in the last 60 days) from the provider and verify the outstanding status of the account and the current balance due. Accounts with payments made by an insurance carrier, including Medicare, must be accompanied by the carrier’s EOB or a Medicare Summary Notice (formerly known as a Medicare Explanation of Benefits) that shows the specific services covered and amounts paid.
When additional information is requested by TMHP-MNC, the applicant has 30 days from the date of the letter to respond. The provider may assist the client by furnishing the additional information to the applicant or sending it directly to TMHP-MNC in a timely manner.

TMHP-MNC does not pay bills; it only applies them toward the spend down. The provider must file a Medicaid claim after eligibility is established to have Texas Medicaid consider the claim for reimbursement. During the spend down period, there is no Medicaid coverage, and bills must not be sent to Texas Medicaid. A claim inadvertently filed to Texas Medicaid is denied due to client ineligibility. Providers may make inquiries regarding status, months of potential eligibility, Medicaid or case number, and general client information by contacting the TMHP Contact Center at 1-800-925-9126, which is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

3.6.3 Claims Filing Involving a Medicaid Spend Down

Clients are responsible for informing their medical providers of their Medicaid eligibility and making arrangements to pay the charges used to meet the spend down amount. For CSHCN Services Program clients, the CSHCN Services Program may consider paying the charges used to meet the spend down for covered services.

TMHP-MNC notifies the client of:

- Bills or charges that were used to meet the spend down.
- Bills or charges that the client is financially responsible to pay.
- Bills or charges that the provider should submit to Texas Medicaid for consideration of payment.

Bills or charges not applied toward spend down or not previously submitted to the CSHCN Services Program, must be received by TMHP for Medicaid consideration. These claims must be received within 95 days from the date the client’s eligibility was added to the TMHP file (add date) and must be on the appropriate claim form (such as CMS-1500 and UB-04 CMS-1450).

The client’s payment responsibilities are as follows:

- When the entire bill was used to meet spend down, the client is responsible for the payment of the entire bill. For CSHCN Services Program clients, submit the bill to the CSHCN Services Program for payment consideration.

- When a portion of a bill was used to meet the spend down, the client is responsible for paying the portion applied toward the spend down. For CSHCN Services Program clients, submit the bill to the CSHCN Services Program for payment consideration.

Claims are subject to the following:

- The claim must show the total billed amount for the services provided. Charges for ineligible days or spend down amounts must not be deducted or included on the claim.

- A client’s payment toward spend down must not be reflected on the claim submitted to TMHP.

Note: Payments made by the client for services that were not used in the spend down but that were incurred during an eligible period must be reimbursed to the client before the provider files a claim with TMHP.

Once eligibility is established, the client is eligible to receive the same care and services available to all other Medicaid clients.

3.7 TMHP-CSHCN Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.