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23.1 Enrollment

To enroll in the CSHCN Services Program, a hospital must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the TMHP-CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state hospitals must meet all of these conditions and be located in New Mexico, Oklahoma, Arkansas, or Louisiana within 50 miles of the Texas state border. Hospital providers must be Medicare-certified.

Freestanding ambulatory surgical centers (ASCs) and hospital ambulatory surgical centers (HASCs) are subject to the same enrollment requirements as hospitals. HASCs must enroll separately from the hospitals in which they are based.

To be eligible for participation in the CSHCN Services Program, a psychiatric hospital or facility must be enrolled in Texas Medicaid as a freestanding inpatient psychiatric facility. Out-of-state psychiatric hospitals or facilities must meet all of these conditions and be located in the United States, within 50 miles of the Texas state border.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. Refer to: Section 24.1.1, “Clinical Laboratory Improvement Amendments (CLIA) of 1988,” on page 24-3 for more information.

Important: CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371. CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.161(6) for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 25 TAC §38.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession or facility standards, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, “Provider Enrollment,” on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

23.1.1 Continuity of Hospital Eligibility Through Change of Ownership

When a hospital changes ownership, the new owner must take the following actions:

• Obtain recertification as a Medicare facility under the new ownership.

• Complete a Texas Medicaid Provider Enrollment Application and obtain a Texas Medicaid provider identifier. The provider must have a Texas Medicaid provider identifier on file before applying with the CSHCN Services Program.

• Provide TMHP with a copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners in a language that specifies who is liable for overpayments that were identified subsequent to the change of ownership, that includes dates of service before the change of ownership).

• Supply a listing of all the providers identified by the change of ownership.
23.1.2 Specialty Team or Center
In addition to requiring prior authorization, the following services require that the physicians or facilities be approved by the TMHP-CSHCN Services Program as specialty team or center providers:

- For stem cell and kidney transplant services, the facility must be specialty center-approved.
- For cleft/craniofacial surgical procedures, only physicians, dentists, and other professional providers constitute an approved specialty team. If the specialty team requirements are not met, all services related to the surgery are denied. For a list of specific procedure codes that require this special designation, refer to Section 30.2, “Benefits, Limitations, and Authorization Requirements,” on page 30-5.

Refer to: Section 2.1.6, “Cleft/Craniofacial (C/C) Specialty Teams,” on page 2-7 for information about specialty team designation.

Section 2.1.7, “Transplant Specialty Centers,” on page 2-7 for more information about stem cell and kidney transplant facility designation.

23.2 Inpatient/Outpatient Benefits, Limitations, and Authorization Requirements
Facilities are responsible for knowing which services require authorization or prior authorization and whether they are a benefit in the inpatient or outpatient setting. The services listed below are not all-inclusive. Refer to the appropriate sections of the provider manual for specific benefit information.

The benefits, limitations, and authorization requirements in this section apply to both inpatient and outpatient services. Additional information specific to inpatient services can be found in Section 23.3, “Inpatient Services,” on page 23-5. Additional information specific to outpatient services can be found in Section 23.4, “Outpatient Services,” on page 23-10 and information on ASCs can be found in Section 23.5, “Ambulatory Surgical Centers,” on page 23-12.

Take-home drugs and supplies are not a benefit of the CSHCN Services Program.

Some procedures require prior authorization or specialty team or center approval. If prior authorization is not obtained as required, the procedures or hospital stay are denied. Authorization is a condition of reimbursement; it is not a guarantee of payment. Faxed transmittal confirmations are not accepted as proof of timely authorization submission.

Authorization or prior authorization is not given if the client is not eligible for the CSHCN Services Program benefits when the request is received by the TMHP-CSHCN Services Program. All claims for these services must meet the 95-day filing deadline.

Providers can fax or mail their written requests along with all other applicable documentation to the following address:

Texas Medicaid & Healthcare Partnership
TMHP-CSHCN Services Program Authorization Department
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4222

Refer to: Chapter 4, “Authorizations and Prior Authorizations,” on page 4-1 for more information, including deadlines and appeal procedures.

23.2.1 Blood Factor Products
Blood factor products are benefits of the CSHCN Services Program. Blood factor products require authorization.

Note: Authorization requests must also be submitted for clients who receive blood factor products in the emergency department.
When submitting claims, providers must identify products using either product names and manufacturers or the National Drug Codes (NDCs), and the following procedure codes. Exceptions to the diagnoses shown below will be considered with medical review, which automatically occurs when the authorization request includes a diagnosis other than one of the codes listed.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Diagnosis Restriction</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1680, J7185, J7190, J7191, J7192, J7198, J7199</td>
<td>2860, 2861, 2862, 2863, 2865</td>
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<td>J7186</td>
<td>2860, 2864</td>
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<td>J7187</td>
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<td>J7189</td>
<td>2860, 2861, 2863, 2869, V8302</td>
</tr>
<tr>
<td>J7193</td>
<td>2861</td>
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</tr>
<tr>
<td>J7195</td>
<td>2861</td>
</tr>
<tr>
<td>J7197</td>
<td>NA</td>
</tr>
</tbody>
</table>

Refer to: Section 4.2, “Authorizations,” on page 4-3 for more information, including deadlines and appeals procedures.

Section 30.2.8, “Blood Factor Products,” on page 30-14 for additional information.

23.2.2 Chemotherapy

Inpatient and outpatient hospitals must use revenue code 636 for reimbursement of the technical component. The appropriate chemotherapy procedure code must be listed on the claim.

Refer to: Section 30.2.11, “Chemotherapy,” on page 30-18 for additional information.

23.2.3 Cochlear Implants

Cochlear implant devices are payable to the facility where the cochlear implantation surgery takes place. Hospitals must submit procedure code L8614 when billing for cochlear implant devices. ASCs and HASCs must submit procedure code L8614 with modifier NU when billing for cochlear implant devices.

Refer to: Section 19.2.5, “Cochlear Implants,” on page 19-11 for additional information.

23.2.4 Electrodiagnostic Testing (Electromyography and Nerve Conduction Studies)

Electromyography (EMG) and nerve conduction studies (NCS) are benefits of the CSHCN Services Program when medically indicated. EMG and NCS are diagnosis restricted and may require prior authorization.

Refer to: Section 30.2.17, “Electrodiagnostic Testing,” on page 30-44.

23.2.5 Fluocinolone Acetonide Intravitreal Implant (Retisert)

Fluocinolone acetonide intravitreal implant is a corticosteroid indicated for the treatment of chronic noninfectious uveitis affecting the posterior segment of the eye. The surgical implant is designed to release fluocinolone acetonide over approximately 30 months.

Procedure code J7311 is a benefit for the CSHCN Services Program for clients 12 years of age or older in a hospital, HASC, or ASC setting. Procedure code J7311 is only considered for reimbursement with a posterior uveitis (36320) diagnosis of more than 6 months in duration and only when the condition has been unresponsive to oral or systemic medication treatment. Prior authorization is required.

Refer to: Section 4.3, “Prior Authorizations,” on page 4-5 for detailed information on prior authorization requirements.
23.2.6 Laboratory Services
Hospital laboratory services are a benefit for inpatient, outpatient, and nonpatient clients. A hospital nonpatient is one who is not registered as an inpatient or an outpatient, but whose laboratory services are performed by the hospital.

All clinical laboratory services may be reimbursed 60 percent of the prevailing charge, except for those hospitals that have been identified by Medicare as sole community hospitals. These hospitals may be reimbursed 62 percent of the prevailing charge for clinical laboratory services provided to hospital outpatients and 60 percent for hospital nonpatients.

Outpatient and nonpatient claims for laboratory services must only reflect tests actually performed by the hospital laboratory; however, hospital laboratories may bill for all of the tests performed on a specimen even if a portion of the tests are done by another laboratory on referral from the hospital submitting the claim.

Hospitals may bill a handling fee (procedure code 99001) for collecting and forwarding a specimen collected by venipuncture or catheterization and sent to a receiving laboratory. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more laboratories. In order to bill a handling fee, the receiving laboratory’s name and address and unique Texas provider identifier (TPI) number must be included on the claim in Blocks 17 and 17B.

To be eligible for reimbursement by the CSHCN Services Program, all laboratories must be certified according to the Clinical Laboratory Improvement Amendments (CLIA) regulations.

Refer to: Chapter 24, “Laboratory Services,” on page 24-1.

23.3 Inpatient Services

23.3.1 Benefits, Limitations, and Authorization Requirements
Inpatient hospital services include medically necessary items and services ordinarily furnished by a CSHCN Services Program hospital or by an approved, enrolled, out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Hospital services must be medically necessary, prior authorized, and are subject to the utilization review requirements of the CSHCN Services Program.

Reimbursement to hospitals for inpatient services is limited to 60 days per calendar year and may accrue intermittently or consecutively. Once 60 days of inpatient care are provided, reimbursement for additional inpatient care is not considered until the next calendar year, except as noted below.

Exception: A benefit of up to 60 additional inpatient days may be granted to a client, to begin on the date of hospital admission, for an approved stem cell transplant.

Inpatient hospital services include the following items and services:

• Room and board in semiprivate accommodations or in an intensive care or coronary care unit, including meals, special diets, and general nursing services. Room and board in private accommodations, including meals, special diets, and general nursing services may be reimbursed up to the hospital’s charge for the most prevalent semiprivate accommodations. Private accommodations are not subject to the semiprivate rate if they are documented by the physician as medically necessary. The hospital must keep this documentation in the client’s record and document the information on the claim.

• Whole blood and packed red blood cells that are reasonable and necessary for the treatment of illness or injury provided they are not available without cost.

• All medically necessary ancillary services and supplies ordered by a physician.

Note: Items for personal comfort or convenience, such as a telephone or television, are not a benefit of the CSHCN Services Program and are not reimbursed, even if they are ordered by a physician.
Initial Inpatient Prior Authorization Requests

All inpatient admissions must be prior authorized. The “CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only,” on page B-46 must be completed to obtain authorization. All applicable information must accompany the request documenting the medical necessity for the inpatient admission and each extension of length of stay.

Note: Friday and weekend admissions may be authorized on the following Monday (or in the case of a holiday, on the next business day) when an emergency exists or when the required medical services cannot be delayed due to the timing of the admission.

All prior authorization request forms must be complete and must include either the surgeon’s or the attending physician’s name and provider identifier on the authorization request form. These physicians and the hospital must be actively enrolled in the CSHCN Services Program to obtain authorization.

If an initial request for prior authorization of an inpatient hospitalization is received for a CSHCN Services Program-enrolled client from a nonenrolled provider, the request is denied. If that provider subsequently enrolls as a CSHCN Services Program provider and submits a claim for these previously denied services within the 95-day claims filing deadline, then the claim may be considered for reimbursement based on the medical necessity of the services. If a provider does not complete the request, or if an initial request for prior authorization was not received from an enrolled provider, then the claim(s) cannot be considered for payment and are denied. All providers must be enrolled in order to receive reimbursement.

If prior authorization for a nonemergency inpatient admission is not requested and approved before the admission, and if a request for authorization is made subsequently and approved, then only the day of the authorization request and subsequent days that were approved may be paid.

Emergency Inpatient Hospital Admissions

Authorization requests for emergency admissions must be completed by the next business day after the admission date for coverage of the entire stay.

Emergency admissions are defined as those that are medically necessary for same day admission from the emergency room or from a provider’s office or clinic. If emergency admissions are not authorized, the CSHCN Services Program covers only emergency care and stabilization services provided in the first 24 hours. If an authorization request is made later than the next business day and is approved, only the emergency care and stabilization services in the first 24 hours, the day of the authorization request, and subsequent days that are approved may be paid. All applicable information must accompany the request documenting the emergent conditions that necessitated the inpatient admission.

Inpatient Hospital Extensions

Extension of previously authorized inpatient dates of service requires prior authorization. Requests for extension of an inpatient stay must be received on or before the next working day following the last authorized day. Except for previously authorized dates of service, any date requested before the date the request is received is denied.

When requesting an extension that includes a surgical procedure, providers must document the surgical procedure as part of the medical necessity for the extension.

Providers must include all supporting documentation showing medical necessity for the extended inpatient stay.

Refer to: Chapter 4, “Authorizations and Prior Authorizations,” on page 4-1 for detailed information about authorization and prior authorization requirements.


23.3.1.1 Inpatient Behavioral Health

The intent in providing inpatient services is to provide resources for behavioral health crisis stabilization while efforts are made to transfer the clients to a more appropriate outpatient program where they may receive the necessary psychiatric/psychological treatment required. Benefits are limited to inpatient assessment and crisis stabilization and must be followed by referral to the Texas Department of State Health Services (DSHS) or other appropriate behavioral health programs. Inpatient behavioral health services are limited to five days per calendar year, which count toward the inpatient hospital limitation of 60 days per calendar year.
Hospital

Inpatient Behavioral Health Prior Authorization Requirements

Inpatient admissions for behavioral health crisis stabilization must be prior authorized. Requests must be received by the TMHP-CSHCN Services Program on the “CSHCN Services Program Prior Authorization Request for Inpatient Psychiatric Care” form before or on the day of the client’s admission, unless the admission is after 5 p.m., or on a holiday, or a weekend. In these cases, the TMHP-CSHCN Services Program must receive it by 5 p.m. on the next business day following admission. The TMHP-CSHCN Services Program will notify the provider of the decision in writing by fax. There may be no extensions to the 5-day limit.

Refer to: Section 4.3, “Prior Authorizations,” on page 4-5 for detailed information on prior authorization requirements.


23.3.1.2 Inpatient Rehabilitation Services

Inpatient rehabilitation programs must include medical management, two or more therapies (e.g., respiratory therapy, speech-language pathology [SLP] services, physical therapy [PT], occupational therapy [OT]), and rehabilitation nursing. The CSHCN Services Program may reimburse inpatient rehabilitation services if the client meets one of the following criteria:

• The client is 5 years of age or older, sufficiently alert to respond to interventions and to participate with the rehabilitation team in setting treatment goals, and is an active participant in therapeutic activities.

• The client is 4 years of age or younger, sufficiently alert to respond to interventions and to participate with the rehabilitation team, and the parent or caregiver can actively participate in setting treatment goals and learning therapeutic management.

In addition, at least one of the following criteria must be met for the client to be eligible for reimbursement of inpatient rehabilitation services:

• The client developed a recent onset of illness or trauma (within the last 12 months) without previous comprehensive rehabilitation efforts.

• There is no documentation of previous inpatient comprehensive rehabilitation effort.

• The client experienced a loss of previous level of functional independence through complications or recurrent illness, and the recovery of functional independence is feasible.

The following are examples of conditions that may be considered for coverage of inpatient rehabilitation:

• Spinal cord injuries

• Traumatic amputation of upper or lower extremities

• Rheumatoid arthritis and other inflammatory polyarthropathies

• Burns

• Postpolio syndrome

• Neoplasms

• Head or brain injuries

• Late effects of infections (i.e., Guillain-Barré syndrome)

• Cerebrovascular diseases

• Congenital conditions (e.g., spina bifida and cerebral palsy) may be considered when there is a recent change in medical and functional status, such as postspinal surgery

Inpatient Rehabilitation Prior Authorization Requirements

Prior authorization is required for inpatient rehabilitation services. An inpatient rehabilitation provider must be enrolled in the CSHCN Services Program as an inpatient rehabilitation facility or unit before a prior authorization may be approved.

Prior authorization may be approved in 14-day increments, not to exceed a maximum of 90 days per calendar year. Requests must be submitted in writing with documentation of medical necessity, including the diagnosis or condition of the client and progress toward goals (request for additional days) along with a copy of the treatment plan. The “CSHCN Services Program Prior Authorization Request for
Inpatient Rehabilitation Admission must be submitted for the initial request and each extension. Providers must include all supporting documentation showing medical necessity for the extended inpatient stay.

A statement explaining the medical necessity of inpatient versus outpatient rehabilitation services must be included with the documentation submitted for prior authorization. The justification must state the client’s current condition and why inpatient rehabilitation, as opposed to outpatient therapy, is required for optimal care. The client’s need for daily, intense, focused, team-directed therapy must be substantiated by the circumstances of the case.

If the prior authorization request for additional days documents that the client has made progress toward treatment goals, an additional 14 days may be approved up to a maximum of 90 days per calendar year.

Requests for additional days must be received for prior authorization before the last inpatient rehabilitation day previously prior authorized.

Requests for extensions are not approved if one of the following conditions applies:
• The client has met treatment goals, as determined by the rehabilitation team or the CSHCN Services Program medical director or designee.
• The client has failed to make progress toward remaining treatment goals during the currently authorized period.
• The client no longer requires inpatient rehabilitation, and therapeutic goals can be met on an outpatient basis.
• The request was received after the last prior authorized inpatient day.
• The 90-day calendar maximum is exhausted.

Treatment for Acute Medical Episodes
If a client has been admitted for inpatient rehabilitation and develops an acute medical condition that prevents participation in rehabilitation program activities, then the CSHCN Services Program must not be billed for inpatient rehabilitation services. Acute care services (whether inpatient or outpatient) that are a benefit of the CSHCN Services Program may require authorization or prior authorization and must be billed as acute care services.

Refer to: Section 4.3, “Prior Authorizations,” on page 4-5 for detailed information on prior authorization requirements.


23.3.1.3 Renal (Kidney) Transplants
Renal transplants will only be approved for reimbursement when performed in a Medicaid-approved, CSHCN Services Program-enrolled transplant facility by a Medicaid-approved, CSHCN-enrolled transplant team. All transplant facilities who wish to perform transplants for CSHCN Services Program clients must have current certification and be in continuous compliance with the criteria set forth by the Organ Procurement and Transportation Network (OPTN). The Centers for Medicare & Medicaid Services maintains a list of certified and approved Texas transplant facilities (www.cms.hhs.gov/ApprovedTransplantCenters).

Renal transplants for clients younger than 15 years of age will only be reimbursed in a Medicaid-approved, CSHCN Services Program-enrolled pediatric renal transplant center.

The CSHCN Services Program may reimburse renal transplants when the projected costs of the transplant and follow-up care are less than continuing dialysis treatments. Clients who have not previously applied for Medicare and Kidney Health Care coverage and are anticipating the need for a renal transplant must apply for Medicare and Kidney Health Care coverage.

Renal transplants must be prior authorized. Only one initial and one subsequent renal transplant may be reimbursed per lifetime.

If the transplant is not prior authorized, services directly related to the transplant within 3 days preoperative and during the 6 weeks postoperative period will be denied for the surgeon, assistant surgeon, and facility. The anesthesiologist may be reimbursed.
A maximum amount of up to $200,000 per client may be reimbursed for a renal transplant hospitalization. Hospitals may be reimbursed 80 percent of the rate allowed by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, which is equivalent to the hospital’s Medicaid interim rate, up to a maximum of $200,000. All hospital charges, including donor costs, are included in the $200,000 limit. Reimbursement for renal transplants includes:

- The cost of the transplant services.
- One of the following:
  - The cost of the procurement of a cadaveric organ and services associated with the organ procurement, when the organ is obtained from an organ procurement organization designated by the U.S. Department of Health and Human Services (documentation validating the organ’s source must accompany the claim).
  - The cost associated with living donors. The donor costs must be included on the client’s inpatient hospital claim and may be reimbursed only if another source of payment is not available. Donor costs for CSHCN Services Program clients who also have Medicaid benefits are not reimbursed.

The costs related to the donor-matching process will not be reimbursed.

If the cost related to a living donor will be paid by the client’s other insurance carrier, the Other Insurance information must be completed on the claim form. If these costs will be paid by the donor’s insurance carrier, the claim must be submitted using a paper claim form with attachments documenting the donor’s insurance information.

Refer to: Section 5.7.1.7, “Instructions for Completing the UB-04 CMS-1450 Paper Claim Form,” on page 5-27.

Renal transplant recipients are eligible for follow-up care (outside the $200,000 limit) immediately following hospital discharge for the renal transplant.

Renal Transplant Authorization Requirements

Prior authorization must be obtained by both the facility and the physician.

Documentation supporting the transplant prior authorization request must include:

- A recent and complete history and physical.
- A statement of the client’s status, including why a transplant is being recommended at this time.
- Information indicating the cost effectiveness of the transplant vs. continued dialysis.


Nationally, stays for renal transplants in hospital are 5 to 10 days followed by outpatient follow-up; therefore, no additional hospital days beyond the 60 per year allowed by the CSHCN Services Program are authorized without an appeal documenting medical necessity.

23.3.1.4 Stem Cell Transplants

The CSHCN Services Program may cover only autologous and matched related and matched nonrelated allogenic transplants (i.e., human leukocyte antigen [HLA] genotypically identical or HLA phenotypically identical, related, and nonrelated).

Stem cell transplants include the initial transplant and one subsequent retransplant due to rejection. This allows a total of two transplants per lifetime regardless of payer. The subsequent transplant must be prior authorized separately from the initial transplant.

Stem cell transplant facilities must be approved as specialty centers by the CSHCN Services Program. Facilities must confirm in writing that the center meets the American Society for Blood and Marrow Transplantation (ASBMT) guidelines in a signed statement in the CSHCN Services Program provider enrollment application. If the specialty center requirements are not met, all services related to the stem cell transplant will be denied.

A maximum amount of $200,000 per client may be reimbursed for a transplant hospitalization. All hospital charges for patient care and donor costs (inpatient hospital only) during the time of the hospital stay are applied to the $200,000 limit. Donor costs must be included on the client’s inpatient hospital claim for the transplant. Donor costs will not be considered by the CSHCN Services Program when another third-party resource is available to reimburse the transplant.
Chapter 23

Transplant protocols that require multiple infusions, stem cell support, stem cell rescue, or multiple inpatient admissions may be reimbursed up to the maximum of $200,000, and are subject to the hospital inpatient 60-day stay limitation, beginning on the day of the hospital admission for the initial transplant procedure. This benefit is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 60-day period is considered a separate inpatient hospital admission for reimbursement purposes. Clients receiving a stem cell transplant are eligible for follow-up care (outside the $200,000 limit) immediately following hospital discharge for the stem cell transplant event. This includes reimbursement for anti-rejection drugs.

Stem Cell Transplant Prior Authorization Requirements
Prior authorization is required for all stem cell transplants and must be obtained by both the facility and the physician.

Refer to: Section 30.2.38.2, “Stem Cell Transplant,” on page 30-127.

23.3.2 Reimbursement Information
Inpatient hospital services may be reimbursed 80 percent of the rate allowed by TEFRA. This is equivalent to the hospital’s Medicaid interim rate. The CSHCN Services Program does not have a separate cost settlement process.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

23.4 Outpatient Services

23.4.1 Benefits, Limitations, and Authorization Requirements
Outpatient services are ambulatory services provided to an individual who is in a hospital, but not admitted for inpatient care. Benefits include those diagnostic, therapeutic, rehabilitative, or palliative items or services provided on an outpatient basis that are deemed medically necessary and are provided by a CSHCN Services Program hospital or under the direction of a physician. Supplies provided by a hospital supply room for use in physician’s offices in the treatment of clients are not reimbursable as outpatient services.

23.4.1.1 Hospital-Based Outpatient Behavioral Health Services
Outpatient behavioral health services are limited to no more than 30 encounters by all providers per eligible client per calendar year. Laboratory and radiological services do not count toward the 30 outpatient encounters. The CSHCN Services Program will not provide outpatient behavioral health benefits for clients who are also enrolled in the Medicaid Texas Health Steps-Comprehensive Care Program (THSteps-CCP) or Children’s Health Insurance Program (CHIP).

Hospitals may be reimbursed for psychological testing (procedure code 96101) and neuropsychological testing (procedure code 96118) in the outpatient setting. Psychological and neuropsychological testing is limited to a total of 4 hours per day and 8 hours per calendar year, per client, by any provider. Interpretation and documentation time, including time to document test results in the client’s medical record, is included in procedure code 96101 or 96118, and is not reimbursed separately. Procedure code 96101 will be denied if performed on the same day as procedure code 96118.

Authorization is not required.


23.4.1.2 Hospital-Based Emergency Services Department
The CSHCN Services Program may cover emergency room visits for program eligible clients when provided in a CSHCN-enrolled facility. An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day, 7 days a week.
According to the federal Emergency Medical Transportation and Labor Act (EMTALA), if any individual presents at the hospital emergency department requesting an examination or treatment the hospital must provide for an appropriate medical screening examination and stabilization services within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists.

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in placing an individual’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The medical records must reflect continued monitoring according to the client’s needs and must continue until the client is discharged, stabilized, or appropriately transferred.

EMTALA medical screening revenue code 451 may be considered for reimbursement when billed as a stand alone service and provided by a qualified medical professional as designated by the facility. Ancillary, professional, or facility services will not be considered for separate reimbursement when billed with revenue code 451. Services beyond screening can be billed with the appropriate corresponding emergency services revenue code 450, 456, 459, 761, or 762.

Hospital-Based Emergency Services Authorization
Authorization is not required for emergency medical services. Emergency department services are subject to retroactive review.

23.4.1.3 Outpatient Observation
Use of observation rooms in an institutional facility is a benefit of the CSHCN Services Program and does not require authorization. Some clients, while not requiring hospital admission, may require an extended period of observation in the hospital environment as an outpatient. While the continued outpatient observation period may be medically necessary, admission to the hospital may not be medically necessary.

Facilities must determine the client’s status using the following guidelines:

- Clients are considered outpatients if they are expected to remain in the hospital for less than 24 consecutive hours and are discharged to home from the outpatient setting. Charges for an observation room must be coded with revenue code 762 and submitted as an outpatient claim. The hospital may designate any of the facility’s beds as observation.
- Charges for an observation room in the inpatient setting must be coded with revenue code 760. The date of inpatient admission for an observation room patient must be the date the client is admitted to the observation room. This rule applies except in those cases when the formal decision to admit the client is made after the midnight census hour. In this case, the date of the inpatient admission is the following calendar day.

Note: Outpatient emergency room charges are not payable in addition to observation room charges.

Hospitals may elect to bill medically necessary services provided during the period of observation as outpatient services. The CSHCN Services Program considers reimbursement of those services provided during the first 23 hours (less than 24 hours) of an outpatient observation period, based on the facility’s reimbursement rate and the medical necessity of the service. Clients may not be held liable for those outpatient services provided on or after the 24th hour.

If the patient status changes from observation to inpatient admission, the date of admission is the date the client was first placed on observation status. The rule applies regardless of the length of time the client was in observation (less than 24 hours) or whether the date of inpatient admission is on the following day. The only exception to this rule is when the formal decision to admit the client is made after the midnight census hour. In this case, the date of the inpatient admission is the following calendar day.

Outpatient Observation Authorization
Authorization is not required for outpatient observation services.

Important: All inpatient admissions require prior authorization. Providers must submit the prior authorization request immediately upon determining that the patient’s status is changing from observation to inpatient.
23.4.2 Reimbursement Information
Outpatient hospital services may be reimbursed 80 percent of the rate allowed by TEFRA. This is equivalent to the hospital’s Medicaid interim rate. The CSHCN Services Program does not have a separate cost settlement process.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

23.4.2.1 Hospital-Based Emergency Services Department
Hospital-based emergency departments may be reimbursed for services based on a reasonable cost, based on the hospital’s most recent tentative Texas Medicaid cost settlement report. The reasonable cost is reduced by a percentage determined by the state.

23.5 Ambulatory Surgical Centers

23.5.1 Benefits, Limitations, and Authorization Requirements
Covered services in a freestanding surgical center or a hospital ambulatory surgical center are billed as one inclusive charge. It is not appropriate to bill separately for any supplies or other services related to the surgery. Routine X-ray and laboratory services directly related to the surgical procedure are not reimbursed separately. All nonroutine laboratory and X-ray services should be billed separately using the hospital’s full care provider identifier.

Day surgery payment represents a global payment. Physician services must be billed separately.

Day surgery services include prosthetic devices, such as an intraocular lens (IOL), when supplied by the day surgery facility and implanted, inserted, or otherwise applied during a surgical procedure that is a benefit. Certain devices, such as cochlear implants and neurostimulator devices, may be reimbursed separately from the global rate.

Authorization for ASCs and HASCs
Authorization is required for all services performed in an ASC or HASC. Some outpatient surgery procedures have specialty team requirements. Refer to individual sections of this manual for additional information.

Refer to: Chapter 4, “Authorizations and Prior Authorizations,” on page 4-1 for more information, including deadlines and appeal procedures.


23.5.1.1 Freestanding Surgical Centers
To be considered for payment, all surgeries performed in a freestanding surgical center must meet the following requirements:

- Child must be 24 months of age or older.
- The client’s current state of health, using the American Society of Anesthesiologists (ASA) physical state classification, must be Level I or II:
  - ASA I or P1: a normal health patient.
  - ASA II or P2: a patient with mild systemic disease.

Services for a client with physical status P3, P4, P5, or P6 cannot be authorized in a freestanding surgical center.

<table>
<thead>
<tr>
<th>ASA Designation</th>
<th>Physical Status Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA I</td>
<td>P1</td>
</tr>
<tr>
<td>ASA II</td>
<td>P2</td>
</tr>
<tr>
<td>ASA III</td>
<td>P3</td>
</tr>
<tr>
<td>ASA IV</td>
<td>P4</td>
</tr>
</tbody>
</table>
Documentation of the client’s physical status must be on the surgery authorization request form. A CSHCN Services Program-enrolled provider must perform the surgical procedure.

### 23.5.2 Reimbursement Information

Reimbursement of ASC procedures, whether HASC or free-standing, is based on the Centers for Medicare & Medicaid Services (CMS)-approved Ambulatory Surgical Code Groupings (Groups 1 through 9 per CMS and group 10 per the Texas Health and Human Services Commission (HHSC)) payment schedule. ASC and HASC procedure code group information can be obtained from the fee schedules on the TMHP website at www.tmhp.com. When two or more procedures are performed at the same surgical event, reimbursement is based on the procedure with the highest group payment.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

### 23.6 Claims Information

Inpatient, outpatient, and HASC claims must be submitted to TMHP in an approved electronic format or on a UB-04-CMS-1450 paper claim form. Freestanding ASC claims must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase UB-04 CMS-1450 or CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

The total number of details allowed for a UB-04 CMS-1450 paper claim form is 28. The TMHP claims processing system accepts a total of 61 details, and merges like revenue codes together to reduce the lines to 28 or less. If the merge function is unable to reduce the lines to 28 or less, the claim will be denied, and the provider will need to reduce the number of details and resubmit the claim.

Note: Each surgical procedure code listed in Block 74 of the claim form is counted as one detail and is included in the 28-detail limitation.

All claims that require prior authorization must include the prior authorization number.

When completing the claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement,” on page 5-1 for additional information about claims filing.

Chapter 37, “TMHP Electronic Data Interchange (EDI),” on page 37-1 for information about electronic claims filing.

### 23.6.1 Inpatient and Outpatient Claims

Hospitals are not required to submit itemized charge tickets with their UB-04 CMS-1450 paper claim forms for inpatient stays. The itemized charges must be retained by the facility for a period of at least 5 years from the date of service.

Medical or surgical supplies (e.g., infusion pumps, traction setups, and crutches only for inpatient use) must be itemized on Block 42-43 of the UB-04 CMS-1450 paper claim form. If provided to all admitted clients, admission kits should be billed using revenue code 270. If laboratory work is sent out, the name and address or provider identifier of the laboratory where the work was forwarded must be entered in Block 80 of the UB-04 CMS-1450 paper claim form or in Block 32 of the CMS-1500 paper claim form.

Emergency department services by facilities for the room charges may be billed using the following revenue codes:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>450</td>
<td>Emergency room</td>
</tr>
<tr>
<td>451</td>
<td>Emergency room - EMTALA</td>
</tr>
</tbody>
</table>
Emergency room ancillary services by facilities include laboratory services, radiology services, respiratory therapy services, and diagnostic studies such as electrocardiogram (EKG), computed tomography (CT) scans, and supplies. Facilities billing outpatient claims (claim type 023) bill for ancillary services using the appropriate procedure code such as the Current Procedural Terminology (CPT) code or the Healthcare Common Procedure Coding System (HCPCS) code that indicates the procedure or service being performed.

If the client visits the emergency room more than once in a day, the time must be given for each visit. The time of the first visit must be identified in Block 18 of the UB-04 CMS-1450 paper claim form, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.

Drugs administered in the outpatient setting must be billed with modifier SH. The drug description must include the name, strength, and quantity of the drug. Take home drugs and supplies are not a benefit of the CSHCN Services Program.

### 23.6.2 HASC Claims

All surgical procedures performed in an ASC or HASC must be billed using the appropriate national procedure code. Day surgery payment represents a global payment. Physician services must be billed separately.

Claims for scheduled outpatient day surgeries performed in an HASC must be filed using the HASC provider identifier and type of bill (TOB) 131 for outpatient hospitals in Block 4 of the UB-04 CMS-1450 paper claim form. Surgical procedures performed in the hospital’s outpatient departments (emergency room, treatment rooms) are to be billed under the hospital’s provider identifier and not under the ASC provider identifier.

Claims for emergency, unscheduled outpatient surgical procedures should be filed with separate charges for all services using TOB 131 and the hospital’s outpatient provider identifier. If a client is admitted for a day surgery procedure, whether scheduled or emergency, and has either an ASA Classification of Physical Status of III, IV, or V or Classification of Heart Disease IV, the surgical procedure must be considered an inpatient procedure and billed on an inpatient claim (TOB 111) using the full care provider identifier. The reason for the surgery (principal diagnosis), any additional substantiated conditions, and the surgical procedure must be included on one inpatient claim.

### 23.6.3 Inpatient Stays Following Scheduled Day Surgeries

If a client suffers a complication following an elective day surgery procedure and requires an inpatient admission, the surgery must be billed as an outpatient service. All inpatient charges must be submitted on a second claim as inpatient services. The diagnosis on the inpatient claim must be the complication that resulted in the admission. The ambulatory surgical procedure must not be listed on the inpatient claim. All inpatient admissions require prior authorization.

Providers must bill the scheduled day surgery using the ASC or HASC provider identifier. If a condition of the scheduled day surgery requires additional care beyond the recovery period, the patient may be placed in outpatient observation (stay less than 24 hours). This outpatient observation stay must be billed using the hospital provider identifier. Care required beyond the outpatient observation period (stay of 24 hours or more) must be billed as an inpatient stay. The admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation placement must be included on the claim. The principal diagnosis to be used is the complication of surgery that necessitated the extended stay.
23.6.4 Inpatient Stays Following Unscheduled (Emergency) Day Surgeries
Providers must bill the unscheduled day surgery as an outpatient claim using the hospital’s provider identifier. If a complication occurs, the same guidelines presented in Section 23.6.3, “Inpatient Stays Following Scheduled Day Surgeries,” on page 23-14, must be followed with the following exception: the date of admission on the outpatient claim must reflect the date of first contact with the client.
Take-home drugs and supplies are not a benefit of the CSHCN Services Program. Drugs administered in the outpatient setting must be billed with modifier SH. The drug description must include the name, strength, and quantity.

23.7 TMHP-CSHCN Services Program 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.