



# TEXAS MEDICAID BULLETIN

Bimonthly update to the Texas Medicaid Provider Procedures Manual

MARCH/APRIL 2012

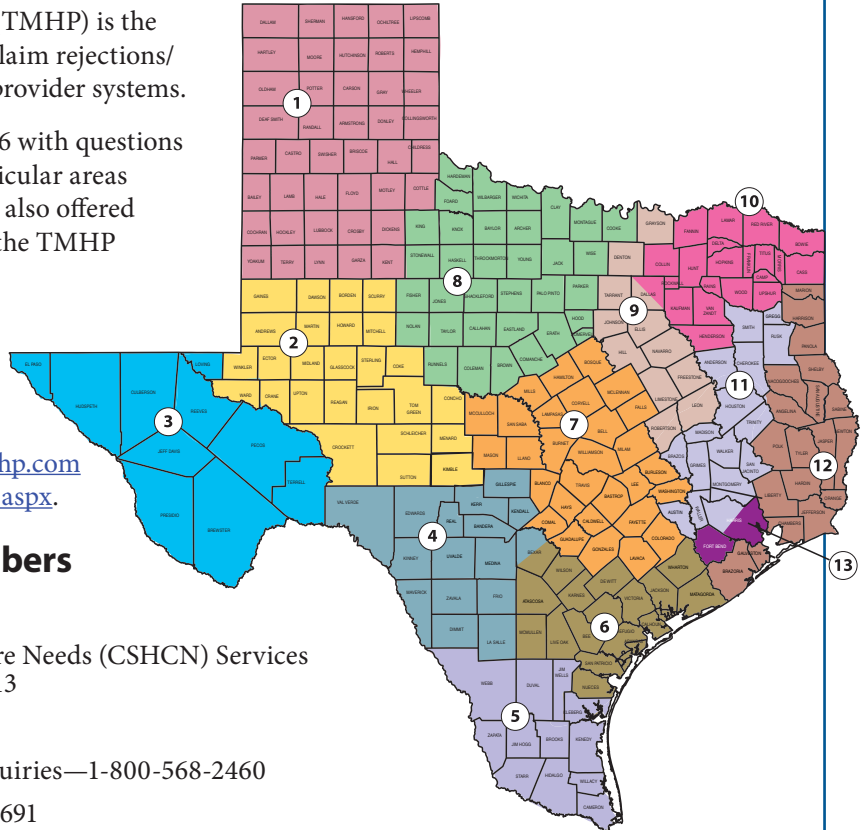
NO. 240

## Provider Relations Representatives

Texas Medicaid & Healthcare Partnership (TMHP) is the main resource for general inquiries about claim rejections/denials and how to use automated TMHP provider systems.

Providers can call TMHP at 1-800-925-9126 with questions and to request on-site visits to address particular areas of provider concern. TMHP workshops are also offered for providers. For current schedules check the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The map on the right indicates the areas served by TMHP provider relations representatives. Additional information, including a regional listing by county, is available on the TMHP website at [www.tmhp.com/Pages/SupportServices/PSS\\_Reg\\_Support.aspx](http://www.tmhp.com/Pages/SupportServices/PSS_Reg_Support.aspx).



### Helpful TMHP Telephone Numbers

- TMHP Contact Center—1-800-925-9126
- TMHP-Children with Special Health Care Needs (CSHCN) Services Program Contact Center—1-800-568-2413
- Telephone Appeals—1-800-745-4452
- Texas Health Steps (THSteps) Dental Inquiries—1-800-568-2460
- THSteps Medical Inquiries—1-800-757-5691
- TMHP electronic data interchange (EDI) Help Desk—1-800-925-9126, option 3
- Automated Inquiry System (AIS)—1-800-925-9126, select option from menu



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### Contact Information

For additional information about Texas Medicaid, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126. For additional information about PCCM articles in this bulletin, call the PCCM Provider Helpline at 1-888-834-7226. For additional information about articles pertaining to the CSHCN Services Program, call the TMHP-CSHCN Contact Center at 1-800-568-2413. For additional information about Dental or Orthodontics, call the TMHP THSteps Dental Inquiries department at 1-800-568-2460.

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## New Medicaid Basics I and II Computer-Based Training (CBT) Now Available

New Medicaid Basics I and II computer-based training courses are now available through the TMHP website at [www.tmhp.com](http://www.tmhp.com). To access the courses, follow these steps:

- 1) Click the **Provider Education** button on any Medicaid web page. The Provider Education homepage appears.
- 2) Click the **Computer-Based Training** button. TMHP’s Learning Management System (LMS) appears in a new window.
- 3) Log in to an existing account or create a new account. New visitors to the LMS can take courses immediately after they register.

Providers can access CBT courses on the LMS at any time. ■

## Resolution for Anesthesia Revenue Code Claim Rejections

TMHP has identified an issue that impacts outpatient hospital claims that were submitted on a CMS-1450 claim form or its electronic equivalent on or after September 1, 2011. Claims that were submitted with anesthesia revenue code 370, 371, 372, 374, or 379 and an anesthesia procedure code may have been rejected if they were electronic, or denied if they were on paper, with one of the following explanation of benefits (EOBs):

EOB #	Message
00424	This procedure requires modifier(s). Please appeal claim with appropriate modifier(s).
00114	Procedure code is invalid or the combination of procedure code and type of service is invalid.

TMHP has implemented a temporary work-around to allow outpatient anesthesia claims to be accepted and processed according to outpatient anesthesia guidelines. Beginning December 22, 2011, providers may resubmit electronic claims for outpatient anesthesia services that were rejected or denied on or after September 1, 2011, with EOB 00424 or 00114.

**Important:** For a claim to be accepted into the TMHP claims processing system and processed appropriately, providers must omit the anesthesia modifiers when they submit outpatient hospital anesthesia claims on the CMS-1450 paper claim form or its electronic equivalent.

Providers must submit claims that have passed the 95-day filing deadline with proof of timely filing. Providers must abide by all claims filing deadlines. Providers can refer to the 2011 *Texas Medicaid Provider Procedures Manual, Vol. 1, General Information*, subsection 6.1.3, “Claims Filing Deadlines,” for more information about timely filing guidelines.

TMHP is developing a permanent solution. Once this issue is resolved, the modifier requirement for these services will be reinstated. Providers will be notified in a future article when the permanent solution has been implemented. ■

## Coming Soon: Annual Potentially Preventable Readmissions Information

Effective January 16, 2012, reports for potentially preventable readmissions (PPR) are available on the TMHP website at [www.tmhp.com](http://www.tmhp.com) when providers log into their TMHP account in accordance with legislative direction.

PPR is defined as a return hospitalization of a client within 15 days of the initial discharge date when the return hospitalization could have been the result of deficiencies in care or treatment provided to the client during a previous hospital stay or in follow-up after hospital discharge.

PPR rates are calculated for services that are rendered to Texas Medicaid clients in acute care facilities. A statewide average rate is calculated for all hospitals within Texas as well as a rate for each individual hospital, which allows hospitals to compare their rate of PPR to the statewide average. A hospital has access only to the statewide average and the hospital's own specific PPR rate. Rates of individual hospitals will not be shared with other hospitals or with the general public at this time.

Claim data for hospital stays that occurred between September 2009 and August 2010 will be used for the reports that are available January 16, 2012. The claim data includes fee-for-service, Primary Care Case Management (PCCM), and Medicaid managed care programs.

In addition to the individual hospital's PPR rate and the statewide average hospital PPR rate, the following information is available through the provider's TMHP website account:

- General information that explains how PPR is one method used to measure health-care quality
- A description of how PPR is calculated
- A data breakdown of PPR rates by types of admissions and types of readmissions
- Detailed claims data used to calculate the provider's specific PPR rate and to contribute to the statewide hospital average

The PPR rates look at combined performance over many acute inpatient stays. The PPR methodology classifies individual hospital admissions as unique and unrelated or as potentially preventable. The methodology does not attempt to classify any stay as specifically or clearly preventable.

PPR rates do not include hospital readmissions caused by unrelated events after discharge. PPR does include readmissions of clients to a hospital for any of the following:

- The same condition or procedure for which the client was previously admitted
- An infection or other complication resulting from care previously provided
- A condition or procedure that indicates that a surgical intervention performed during a previous admission did not achieve the anticipated outcome
- Another condition or procedure of a similar nature to the original admission, as determined by the executive commissioner

The Texas Health and Human Services Commission (HHSC) provides this information to help hospitals measure their quality of care and to make decisions about how it can be improved. PPR information should help providers focus their attention on the critical time of transition between inpatient and outpatient phases of treatment for an acute illness. PPR information can highlight complications from treatment that become evident only after discharge.

Providers may submit questions about the PPR report to [PPR.Report@tmhp.com](mailto:PPR.Report@tmhp.com). ■

## Medicaid Managed Care Organizations Must Maintain Special Investigative Units

A managed care organization (MCO) that provides or arranges for the provision of health-care services under Texas Medicaid must establish and maintain a Special Investigative Unit (SIU) that works in cooperation with the Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) and the Attorney General's Office Medicaid Fraud Control Unit (OAG-MFCU), as required by Texas Government Code §§533.012, 531.113, and 531.1131 and Title 1 Texas Administrative Code (TAC) §§353.501–353.505 and 370.501–370.505.

An MCO SIU must refer a case to both the HHSC-OIG and OAG-MFCU in the following situations:

- When fraud, waste, or abuse is discovered in Medicaid or the Children's Health Insurance Program (CHIP), the MCO SIU must immediately notify the HHSC-OIG and OAG-MFCU and begin payment recovery efforts, unless the HHSC-OIG or OAG-MFCU notifies the MCO to stop the recovery effort, as provided in Texas Government Code §531.1131.
- When possible fraud, waste, or abuse are discovered in the Medicaid or CHIP programs, the MCO SIU must refer the alleged fraud or abuse to HHSC-OIG within 30 working days of completing a review.
- When there is reason to believe that a delay in the referral may result in harm or death to patients, loss, destruction, or alteration of valuable evidence, significant monetary loss that may not be recoverable, or hindrance of an investigation or criminal prosecution of the offense, the MCO SIU must refer the alleged fraud or abuse to the HHSC-OIG.

■ ■ ■

## TPIs Without Claims or Encounters Activity for At Least 24 Months are End-Dated

**Reminder:** TMHP sends a courtesy letter to all providers who have a Texas Provider Identifier (TPI) that have not had any claim activity during the previous 18 months. The letter informs providers that to keep their TPIs active they must submit a claim using the TPI referenced on the letter within six months from the date on the letter.

TMHP will deactivate any TPI that has had no claim activity by the deadline in the courtesy letter and will notify the provider that the TPI has been deactivated. A TPI that is deactivated for fee-for-service Medicaid is also deactivated for all other Texas state health-care programs.

To reactivate a TPI, the provider must complete an enrollment application.

Claims that are submitted with a deactivated TPI will be denied. Providers will not be able to access electronic copies of Remittance and Status (R&S) Reports or file appeals electronically for the deactivated TPI.

Providers who submit claims to the North Star Health Maintenance Organization (HMO) program may contact TMHP to file an exemption to the 24-month inactivity requirement to prevent deactivation of TPIs, since their informational claims are not submitted directly to TMHP.

Providers may request a paper copy of the R&S Reports for a deactivated TPI through the TMHP Contact Center and must file appeals on paper. ■

## EDI Version 5010 Deadline Extended to April 1, 2012

This is an update to an article titled “5010 Readiness Deadline to Remain January 1, 2012, Until Further Notice,” which was posted on November 22, 2011, on the TMHP website at [www.tmhp.com](http://www.tmhp.com). The article stated that providers must be ready to submit EDI transactions to TMHP using EDI Version 5010 by January 1, 2012.

As stated in the article, the Centers for Medicare & Medicaid Services (CMS) has extended the date for providers to be compliant with EDI Version 5010 to April 1, 2012. TMHP now plans to adhere to this new date.

Although TMHP has extended the compliance date to April 1, 2012, providers are encouraged to become compliant and ready to submit EDI transactions to TMHP using EDI Version 5010 as soon as possible. Providers can review the statement that was issued by CMS on November 17, 2011.

Providers should direct all questions and support requests to the EDI Version 5010 Implementation email address at [EDI5010Support@tmhp.com](mailto:EDI5010Support@tmhp.com). ■

## OPL Enhancements That Identify Urgent Care Providers

Effective January 27, 2012, urgent care providers are able to self-declare as urgent care centers within the Provider Information Management System (PIMS). The Online Provider Lookup (OPL) search page has been updated with these self-declarations to allow clients to search for urgent care centers as an alternative to hospital emergency rooms for treatment of non-emergent conditions.

An urgent care center is defined as a provider location that is distinct from a hospital or emergency room and offers extended office hours to diagnose and treat non-life-threatening illness or injury for unscheduled, ambulatory patients who are seeking immediate medical attention.

PCCM clients who visit an urgent care center for services must have a referral form on hand from their primary care provider (PCP) in order for the center to be reimbursed for services rendered; however, urgent care centers that provide after-hours services to PCCM clients can be considered for reimbursement of services without a referral from a PCP. Claims for these services must be billed using the TU modifier.

For clients enrolled in an MCO, contact the MCO for their requirements. ■

## Scheduled System Maintenance

System maintenance for the TMHP claims processing system is scheduled as follows:

- March 11, 2012, 4:00 p.m. to 11:59 p.m.
- April 15, 2012, 4:00 p.m. to 11:59 p.m.

During scheduled system maintenance, some applications related to the claims engine will be unavailable. Details about the affected applications are available on the TMHP website at [www.tmhp.com](http://www.tmhp.com). ■



## TexMedConnect Acute Care Eligibility Verification Submission Process to Change February 24, 2012

Effective February 24, 2012, the way providers submit eligibility verification requests through TexMedConnect will change. Providers will be required to submit additional information with the acute care client ID for either Texas Medicaid or the CSHCN Services Program. Providers will no longer be able to search for client eligibility by submitting the client ID alone.

Providers will be able to choose from the following search combinations when submitting an eligibility search through TexMedConnect:

- Client ID (Medicaid or CSHCN Services Program number) + Social Security Number (SSN)
- Client ID (Medicaid or CSHCN Services Program number) + date of birth
- Client ID (Medicaid or CSHCN Services Program number) + last name
- SSN + last name
- SSN + date of birth
- Date of birth + last name and first name

**Note:** *The new search combinations will also apply to Client Group List (Batch) submissions.*

Requests that are submitted without one of the six valid search combinations will prompt an error message that directs the user to enter one of the valid field combinations.

This change is designed to enhance the security of TexMedConnect acute care eligibility verification submissions and safeguard client protected health information (PHI). ■



### Note Code 8 Definition Not Appearing in Online Fee Lookup

Providers who are seeking historical rate information on the Online Fee Lookup (OFL) for dates of service on or before December 31, 2010, may find no definition when note code 8 is referenced. Note code 8 will appear only if the provider type is either physician assistant (PA)/nurse practitioner (NP)/clinical nurse specialist (CNS) or registered nurse/nurse midwife (CNM).

The following is the definition for note code 8:

*For APN/PA/CNM providers, the displayed fee reflects 92 percent of the fee applicable to a physician for the same service.*

Note code 8 was discontinued for dates of service on or after January 1, 2011. However, the definition will be added back to the OFL to maintain historical accuracy. ■

# Changes to Medicare Crossover Claims Processing and Reimbursement

Effective for dates of service on or after January 1, 2012, the following claims submission and processing guidelines have changed for Medicare crossover claims:

- Coinsurance and deductible reimbursement has changed for professional and outpatient facility crossover claims in accordance with cost containment reductions included in H.B. 1, 82nd Legislature, Regular Session, 2011.
- If a TMHP Standardized Medicare and Medicare Advantage Plan (MAP) Remittance Advice Notice Form (i.e., MRAN template) is included with a paper crossover submission, the Medicare Remittance Advice (RA) or Remittance Notice (RN), other approved notice that is issued by Medicare, or the MAP EOB must also be submitted to TMHP.
- The performing provider information is required for electronic and paper submissions billed by group providers.
- The TMHP Standardized Medicare and MAP Remittance Advice Notice Forms (i.e., MRAN template) for paper crossover submissions has been updated to include additional required fields.

## Coinsurance and Deductible Reimbursement for Professional and Outpatient Facility Crossover Claims

Effective for dates of service on or after January 1, 2012, coinsurance and deductible reimbursement for Medicare Part B and Part C (noncontracted MAPs only) professional and outpatient facility crossover claims have changed for Texas Medicaid in accordance with cost containment reductions included in H.B. 1, 82<sup>nd</sup> Legislature, Regular Session, 2011.

The mandated changes align the Texas Medicaid payment policy for Medicare Part B and Part C (noncontracted MAPs only) with the Texas Medicaid payment policy for Medicare Part A.

For Part B and Part C (noncontracted MAPs only) professional and outpatient facility crossover claims, Texas Medicaid will reimburse the lesser of the following:

- The coinsurance and deductible payment
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service

If the Medicare payment is equal to or exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid will not make a payment for coinsurance and deductible.

**Important:** *The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.*

**Refer to:** The 2011 *Texas Medicaid Provider Procedures Manual, Vol. 1, General Information*, Subsection 1.4.9, "Billing Clients."

For crossover claims that are submitted by nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers, Texas Medicaid will continue to pay the Medicare coinsurance and deductible less five percent.

HHSC makes a per-client-per-month payment to MAPs that contract with HHSC. The payment to the MAP includes all costs associated with the Medicare coinsurance and deductible for a client who is dually eligible

for Medicare and Medicaid. TMHP does not reimburse the coinsurance or deductible amounts for these claims. These costs must be billed to the MAP and must not be billed to TMHP or the Medicaid client.

## Performing Provider Requirement for Group Providers That Submit Professional Crossover Claims

Effective January 1, 2012, if the billing provider is a group, the performing provider information must be submitted on all professional crossover claims as follows:

- **Paper claim submissions.** The performing provider's National Provider Identifier (NPI) and Texas Provider Identifier (TPI) must be submitted on each detail line item. A detail line item will be denied if the performing provider NPI or TPI is omitted, if the performing provider NPI is not associated with the TPI according to the performing provider's enrollment information, or if the performing provider is not a member of the billing group provider.
- **Electronic claim submissions.** Claims are processed using the performing provider NPI submitted on the Medicare claim. If the performing provider NPI is invalid or not a member of the billing group provider, the claim will be denied. Denied claims may be appealed on paper with the appropriate performing provider information.

If the appropriate performing provider information is not on the claim, the claim will be denied.

**Important:** The performing provider identified on the paper or electronic claim must be a member of the billing group provider. If the performing provider is not a member of the billing group provider, the detail line item will be denied.

Individual billing providers (i.e., billing providers that are not groups) are not required to submit a performing provider TPI.

## TMHP Standardized Medicare and MAP Remittance Advice Notice Forms for Paper Submissions

Effective for dates of service on or after January 1, 2012, providers that submit the TMHP MRAN template are also required to submit the paper MRAN from Medicare or a Medicare intermediary, or the computer generated MRAN from the CMS-approved software applications, which are Medicare Remit Easy Print (MREP) for professional services and *PC-Print* for institutional services.

Providers that currently submit only the Medicare notice for paper crossover claims must include the appropriate TMHP MRAN template if the Medicare notice does not contain all of the required information.

The TMHP MRAN templates have been updated to accommodate the claims processing and reimbursement changes for professional and outpatient facility crossover claims:

- Crossover Professional Claim Type 30
- Crossover Outpatient Facility Claim Type 31
- Crossover Inpatient Hospital Claim Type 50

The revised MRAN templates are available on the TMHP website. The following changes apply to these forms:

- The Medicare internal control number (ICN) and the MAP ICN (if applicable) are required fields. Claims will be denied if the ICNs are omitted.

- For the TMHP claim type 30 MRAN template, the performing provider TPI and NPI are required fields. Claims will be denied if required performing provider information is omitted or invalid.  
**Note:** *Individual billing providers (i.e., billing providers who are not groups) are not required to fill out the performing provider fields on the TMHP claim type 30 MRAN template.*
- For the TMHP claim type 31 MRAN template, the detail line items are required fields. Claims without coinsurance and/or deductible on the details may not be reimbursed appropriately.

By submitting an MRAN template to TMHP, the provider attests that the information included in the form matches the Medicare RA or RN that was received either from Medicare or the MAP. If the information on the crossover claim type form does not exactly match the information on the RA or RN, the claim may be denied.

**Reminder:** TMHP MRAN templates, paper MRANs from Medicare or a Medicare intermediary, or computer-generated MRANs from the CMS-approved software applications (MREP for professional services or PC-Print for institutional services) must be received by TMHP within 95 days of the Medicare date of disposition to be considered for processing. Providers may also submit Medicare adjusted claims by submitting the adjusted computer-generated MRANs from the CMS-approved software applications (MREP for professional services and PC-Print for institutional services), or paper adjusted MRANs that were received from Medicare or a Medicare intermediary. ■

## Additional Valid NDC Codes Added Retroactively Effective November 16, 2011

Effective November 16, 2011, the following National Drug Codes (NDCs) were added retroactively as valid to submit with Texas Medicaid claims for medical services procedure codes J0696, J0886, J7195, J9178, and J9263:

Procedure Codes	NDC's			
J0696	68180-0644-01	68180-0611-01	68180-0622-01	68180-0633-01
J0886	55513-0478-10			
J7195	58394-0633-03	58394-0634-03	58394-0635-03	58394-0636-03
J9178	25021-0203-51			
J9263	41616-0178-40			

Affected claims that were submitted within the last 24 months will be reprocessed. When the claims are reprocessed, providers may receive additional payment, which will be reflected on R&S Reports.

**Note:** *The Noridian NDC/Healthcare Common Procedure Coding System (HCPCS) crosswalk provides a listing of NDCs that are assigned to HCPCS procedure codes. The crosswalk is a valuable resource for providers, but it may not contain a complete listing of all NDCs for any given procedure code.*

Providers who believe that NDCs are missing for a specific HCPCS procedure code may send an email to [oversight@hhsc.state.tx.us](mailto:oversight@hhsc.state.tx.us) to request that research be performed. The provider will need to provide the procedure code in question and the corresponding NDCs that the provider believes are missing from the Noridian crosswalk.

All HCPCS procedure codes that are on the Noridian NDC/HCPCS crosswalk, with the exception of durable medical equipment procedure codes, require an NDC to be submitted with the HCPCS procedure code. ■

## FQHCs Must Attest to Affiliate Agreements

Effective January 1, 2012, all federally qualified health centers (FQHC) must identify and attest that all contractual affiliation agreements with contracted providers have been submitted to and approved by the Bureau of Primary Health Care (BPHC). This is a mandate from the 2012-2013 General Appropriations Act, H.B. 1, 82<sup>nd</sup> Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 78).



An affiliation agreement is defined as a contract for the provision of FQHC services and includes contracts for the services of a chief financial officer, a chief medical officer, or for billing services. Affiliations do not include contracts for the direct employment of providers or staff. The attestation shall be made using a standardized attestation form, which is available on page 62 of this bulletin, and on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

Existing FQHCs must submit an initial attestation form by January 31, 2012. Such initial attestation forms shall identify all currently existing affiliation agreements. If a provider's attestation form has not been received by this date, TMHP will place a payment hold on claims until all documentation has been received. Funds will be released after all documentation has been processed.

Starting January 1, 2012, current FQHCs must identify new affiliation agreements and attest that such contractual affiliations have been submitted and approved by BPHC prior to implementation. Newly enrolling FQHCs must complete the attestation form before the enrollment process can be finalized.

### FQHCs With Affiliation Agreements

FQHCs that have an affiliation agreement must check the "Yes" box on the form, sign and date the form, and send it back to TMHP by January 31, 2012. These providers must also submit the following to TMHP:

- A Principal Information Form (PIF2)\* for the affiliate
- A copy of the affiliate contract that was approved by the Health Resources and Services Administration (HRSA)

FQHCs that are waiting on supporting documentation from BPHC, including the approved affiliate contract must check the box on the attestation form that BPHC documentation is still pending, attach the BPHC letter, sign and date the form, and send it to TMHP. When documentation from BPHC is pending, providers will have until July 31, 2012, to submit all necessary paperwork to TMHP to avoid a payment hold on claims.

FQHCs that submitted their attestation form by January 31, 2012, must also submit a full BPHC checklist by July 31, 2012, to TMHP if they check "Yes" on the attestation form or have documentation pending from BPHC.

A copy of the BPHC checklist is available on page 60 of this bulletin.

### FQHCs Without Affiliation Agreements

FQHCs that do not have an affiliate agreement must check the "No" box on the attestation form and send the signed and dated form to TMHP by January 31, 2012.

\* The Principal Information Form (PIF2) is available on page 56 of this bulletin.



## Age Clarification for Fee Schedules and Online Fee Lookup

This is a clarification of information in the Texas Medicaid fee schedules and OFL for Texas Medicaid and the CSHCN Services Program. The age ranges that are shown for procedure codes may not reflect the actual age limitations that are associated with the procedure codes.

To obtain specific age limitations for individual procedure codes, providers can search the materials available on the TMHP website at [www.tmhp.com](http://www.tmhp.com) (current provider manuals, bulletins, and website articles) by searching for the procedure code in the OFL and then clicking the **View** button for the procedure code.

Providers can also refer to the *Current Procedural Terminology* coding manual, or *Healthcare Common Procedure Coding System* (HCPCS) coding manual. ■

## Changes to Static Fee Schedules

Effective December 16, 2011, advanced practice nurse is no longer a searchable provider type in the provider type field on the static fee schedule page of the TMHP website at [www.tmhp.com](http://www.tmhp.com). Instead, this provider type has been replaced by “physician assistant/nurse practitioner/clinical nurse specialist.”

The static fee schedule titled “Nurse Practitioner, Clinical Nurse Specialist, and Physician Assistant” has been replaced by two new static fee schedules titled “Physician Assistant” and “Nurse Practitioner/Clinical Nurse Specialist.” ■

## Claims for Cardiac Event Monitoring Submitted with Procedure Codes 93228, 93229, and 93268

Providers may submit Medicaid claims for cardiac event monitoring using procedure codes 93228, 93229, and 93268.

The following table shows which providers may submit claims for cardiac event monitoring and in which settings:

Procedure Code	TOS	Providers	Settings
93228	5	County Indigent Health Care Program (CIHCP), physician	Office
93229	1	CIHCP, physician, clinical nurse specialist, nurse practitioner, physician assistant	Office, inpatient hospital, outpatient hospital
93268	5	CIHCP, physician, portable X-ray supplier, radiological laboratory, physiological laboratory	Office
		Hospital	Outpatient

TOS = Type of Service, TOS 1 = Medical, TOS 5 = Laboratory total component

Providers can refer to the OFL for a list of procedure codes that are payable to different provider types. ■

## Reimbursement Rate Change for Nutritional Supplies Postponed

The reimbursement rate changes for nutritional supplies (enteral and parenteral) services that were proposed at the November 16, 2011, rate hearing will not be implemented for dates of service on or after January 1, 2012.

Providers should monitor the HHSC website at [www.hhsc.state.tx.us/news/meetings.asp](http://www.hhsc.state.tx.us/news/meetings.asp) for information related to a public rate hearing for these reimbursement rates, which will be held at a future date. ■

### Initial Reimbursement Rate for Procedure Code G0257 Established

This is an update to the article titled “Benefit Criteria to Change for Renal Dialysis Services for Texas Medicaid Effective January 1, 2012,” which was published on the TMHP website at [www.tmhp.com](http://www.tmhp.com) on December 7, 2011.

Procedure code G0257, which became a benefit on January 1, 2012, has an initial reimbursement rate of \$477.43. This reimbursement rate does not reflect any current or future rate reductions that may apply. ■

## Benefit Criteria for Cranial Molding Orthosis to Change Effective February 1, 2012

Effective for dates of service on or after February 1, 2012, the benefit criteria for cranial molding orthosis will change for Texas Medicaid.

Cranial molding orthosis (procedure code S1040) will no longer require prior authorization for clients who are 3 months through 12 months of age with a diagnosis of synostotic plagiocephaly (diagnosis code 7560). Providers must keep documentation of medical necessity in the client’s medical record.

Procedure code S1040 is limited to one per lifetime. Additional devices will 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.

Clients who have congenital conditions or duration of need that is not listed above may be considered for prior authorization by the Medical Director on a case-by-case basis with documentation of medical necessity.

The use of a cranial molding orthosis for the treatment of positional plagiocephaly is considered cosmetic and, therefore, is not a benefit of Texas Medicaid. ■

## Benefit Criteria to Change for Botulinum Toxin Types A and B Effective March 1, 2012

Effective for dates of service on or after March 1, 2012, benefit criteria will change for botulinum toxin types A and B for Texas Medicaid.

Procedure code J0585 will no longer be a benefit when submitted with one of the following diagnosis codes:

Diagnosis codes									
34460	34461	34481	34489	3449	3518	47879	72982	78072	

Procedure code J0586 will no longer be a benefit when submitted with one of the following diagnosis codes:

Diagnosis codes									
34400	34401	34402	34403	34404	34409	3441	3442	34430	34431
34432	34440	34441	34442	3445	34460	34461	34481	34489	3449
3518	37800	37801	37802	37803	37804	37805	37806	37807	37808
37810	37811	37812	37813	37814	37815	37816	37817	37818	37820
37821	37822	37823	37824	37830	37831	37832	37833	37834	37835
37840	37841	37842	37843	37844	37845	37850	37851	37852	37853
37854	37855	37856	37860	37861	37862	37863	37871	37872	37873
37881	37882	37883	37884	37885	37886	37887	3789	47879	72982
78072									

Procedure codes J0585 and J0586 will be a benefit when submitted with the following additional diagnosis codes:

Procedure code J0585									
3331	3332	33371	33379	33385	34210	34670	34671	34672	34673
43820	43821	43822	43830	43831	43832	43840	43841	43842	43850
43851	43852	43853	43889	5277	5650	72871	78442	78449	
Procedure code J0586									
34210	72871								

Procedure code J0587 will be restricted to diagnosis codes 33383 and 5277.

The following changes will be applied to the indicated procedure codes:

Procedure Code	Changes
J0585	Will be a benefit when rendered in the office setting by podiatrist providers. Will no longer be a benefit when rendered in the home setting by any provider type.
J0586	Will be a benefit when rendered in the office setting by NP, CNS, PA, or podiatrist providers.

## Benefit Limitations for Botulinum Toxin Types A and B

The benefit limitations for procedure codes J0585, J0586, J0587, and J0588 will be as follows:

Procedure Codes	Quantity Limitations of medication	Billing Units
J0585	360 units	One billing unit is equal to 1 unit of medication. <i>Example:</i> A provider that administers 360 units of medication would submit a claim for a quantity of 360.
J0586	1,000 units	One billing unit is equal to 5 units of medication. <i>Example:</i> A provider that administers 1,000 units of medication would submit a claim for a quantity of 200.
J0587	10,000 units	One billing unit is equal to 100 units of medication. <i>Example:</i> A provider that administers 10,000 units of medication would submit a claim for a quantity of 100.
J0588	120 units	One billing unit is equal to 1 unit of medication. <i>Example:</i> A provider that administers 120 units of medication would submit a claim for a quantity of 120.

Claims that exceed the benefit limitations may be considered on appeal with documentation of medical necessity.

If a client is administered botulinum toxins more frequently than every 12 weeks, the claims must be submitted with documentation of medical necessity that justifies why the medication was given at an interval sooner than 12 weeks.

The following documentation must be included in the client’s medical record:

- Support for the medical necessity of the botulinum toxin injection
- A covered diagnosis
- Dosage and frequency of the injections
- Support for the clinical effectiveness of the injections
- Specific site(s) injected

Supplies for the administration of botulinum toxin type A or B are not reimbursed separately. Providers cannot submit separate claims for supplies.

Only the actual amount of drug that is administered is a benefit of Texas Medicaid. Providers cannot submit claims for discarded amounts of botulinum toxin drugs.

## Reimbursement Limitations

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

Column A Procedure Codes denied when submitted with:	Column B Procedure Codes
J0586, J0587, and J0588	J0585
J0587 and J0588	J0586
J0587	J0588



## Benefit Criteria Has Changed for Renal Dialysis Services for Texas Medicaid Effective January 1, 2012

Effective for dates of service on or after January 1, 2012, benefit criteria for renal dialysis services have changed for Texas Medicaid.

For some medical situations in which end-stage renal disease (ESRD) clients cannot obtain their regularly scheduled dialysis treatment at a certified ESRD facility, Texas Medicaid will allow for non-routine dialysis treatments furnished in the outpatient department of a hospital that does not have a certified dialysis facility.

Unscheduled dialysis for clients may be a benefit for one of the following reasons:

- Dialysis was performed following or in connection with a vascular access procedure.
- Dialysis was performed following treatment for an unrelated medical emergency (e.g., a client goes to the emergency room and, as a result, misses a regularly scheduled dialysis treatment that cannot be rescheduled).
- Emergency dialysis was performed for clients who would otherwise have to be admitted as inpatient in order for the hospital to receive payment.

Providers must submit claims using procedure code G0257 with revenue code 880 in order to receive payment for unscheduled outpatient dialysis.

Procedure code G0257 is limited to diagnosis codes 5855 and 5856 and is limited to one service per day, any provider.

Texas Medicaid will provide a single payment to reimburse unscheduled or emergency dialysis treatments furnished to ESRD clients in the outpatient department of a hospital that does not have a certified ESRD facility.

Reimbursement for procedure code G0257 is limited to the same services included in the Method 1 composite. Providers will not be reimbursed for individual services related to dialysis.

Other outpatient hospital services will be reimbursed only if they are not related to the dialysis services and are determined to be medically necessary with supporting documentation.

Repeated billing of this service by the same provider for the same clients may indicate routine dialysis treatments are being performed, and providers will be subject to recoupment following review of medical records. ■

### Some Sleep Services are a Benefit of Texas Medicaid and the CSHCN Services Program

Effective February 1, 2012, the professional component of the sleep services procedure codes 95805, 95807, 95808, 95810, and 95811 are a benefit of Texas Medicaid and the CSHCN Services Program when services are rendered in the inpatient hospital setting by a physician provider.

These services are also a benefit of Texas Medicaid when they are rendered in the inpatient hospital setting by a County Indigent Health Care Program provider. ■

# Wound Care Management Services Benefit Criteria Have Changed

Effective for dates of service on or after January 1, 2012, benefit criteria for wound care management services has changed for Texas Medicaid.

## New Benefits

Procedure codes 97597 and 97598 are a benefit when rendered in the office or outpatient setting by NP, CNS, PA, physician, dentist, podiatrist, or physical therapist providers.

Procedure codes 97597 and 97598 are a benefit when rendered in the inpatient setting by physician, dentist, or podiatrist providers.

The following reimbursement rates apply for procedure codes 97597 and 97598:

TOS	Procedure Code	Age Range	RVU 1/1/2012	CF 1/1/2012	Fee 1/1/2012	Percent Reduction 1/1/2012	Adjusted** Fee 1/1/2012
1	97597	0-20	0.71	\$28.640	\$20.33	2%	\$19.92
1	97597	21-999	0.71	\$27.276	\$19.37	2%	\$18.98
1	97598	0-20	0.34	\$28.640	\$9.74	2%	\$9.55
1	97598	21-999	0.34	\$27.276	\$9.27	2%	\$9.08

TOS = Type of service, TOS 1= Medical, RVU = Relative value unit, CF = Conversion factor  
 \*\*Adjusted fees reflect mandated reductions

## Benefit Changes

Changes to benefits apply to the following procedure codes:

Procedure Codes	Benefit Changes
Q4100, Q4101, Q4106, and Q4107	Are no longer diagnosis-restricted.
Q4100	Is no longer a benefit when rendered in the outpatient setting by hospital providers.
Q4112, Q4113, and Q4114	Are a benefit when rendered in the outpatient setting by freestanding/independent or hospital-based ambulatory surgical center providers.

## Wound Care Management Services

Wound care management includes the care of acute and chronic wounds, which include, but are not limited to, open ulcers (venous pressure or diabetic ulcers), fistulas, or erosion of skin related to cancer.

Wounds are either acute or chronic and are defined as follows:

- Acute wounds – Wounds taking less than 30 days for complete healing
- Chronic wounds – Wounds taking more than 30 days for complete healing

Wound care includes the following:

- Optimization of nutritional status
- Debridement by any means to remove devitalized tissue

- Maintenance of a clean, moist bed of granulation tissue
- Necessary treatment to resolve any infection that may be present

Based on the type of wound, wound care may include the following:

- Frequent repositioning of a client who has a pressure ulcer
- Off-loading pressure and good glucose control for a client who has a diabetic ulcer
- Establishment of adequate circulation for a client who has an arterial ulcer
- Use of a compression system for clients who have a venous ulcer

Measurable signs of improved healing include the following:

- A decrease in wound size, either in surface area or volume
- A decrease in amount of exudate
- A decrease in amount of necrotic tissue

Wound care must be performed by a licensed health professional who is qualified to safely and effectively provide the medically necessary care. Providers are expected to exercise their clinical judgment to render the most appropriate care in accordance with their scope of practice as designated by their regulatory and governing boards.

Wound care management includes first- and second-line therapies. First-line wound care is used for acute wounds. If the wound does not improve with first-line treatment, adjunctive second-line therapy may be used.

## **First-Line Wound Care Therapy**

First-line wound care therapy includes the following:

- Cleansing, antibiotics, and pressure off-loading
- Compression
- Debridement
- Dressing
- Whirlpool for burns

## **Cleansing, Antibiotics, and Pressure Off-loading**

Wound cleansing helps to create an optimal healing environment and decreases the potential for infection by loosening and removing cellular debris and residual topical agents from previous dressings.

Wound cleansing agents may include normal saline, commercial wound cleansers, povidone iodine, hydrogen peroxide, or sodium hydrochlorite. Cleansing solutions and methods vary based on effectiveness and individual client needs.

Systemic or topical antibiotics may be used to prevent or treat wound infections and to aid in the healing of chronic wounds.

Pressure off-loading devices such as pillows, boots, mattresses, and protectors may also be used as part of first-line wound care therapy to prevent or relieve pressure on the wound.

## Debridement

Selective debridement consists of the following:

- Conservative sharp debridement
- High-pressure lavage to selected areas

Non-selective debridement consists of the following:

- Autolytic debridement
- Blunt debridement
- Enzymatic debridement
- Hydrotherapy and wound immersion
- Mechanical debridement

Wound debridement includes the pre-debridement wound assessment, the debridement, and the post-procedure instructions provided to the client on the date of service.

The procedure code submitted must reflect the level of debrided tissue, e.g., partial-thickness skin, full-thickness skin, subcutaneous tissue, muscle, and bone, and not the extent, depth, or grade of the ulcer or wound.

The following procedure codes are a benefit for wound debridement:

Procedure Codes									
11000	11001	11042	11043	11044	11045	11046	11047	16020	16025
16030	97597	97598							

Wound debridement may be submitted for reimbursement by physician, NP, CNS, PA, dentist, and podiatrist providers who are licensed by the state of Texas to perform these procedures.

Professional services for selective wound debridement (procedure codes 97597 and 97598) may also be reimbursed to a licensed physical therapist or physical therapy group, when the service is determined to be within the provider’s scope of practice and the service is prescribed by a Medicaid-enrolled supervising physician or qualified non-physician provider.

Whirlpool therapy for wound care (procedure code 97602) is bundled into procedure codes 97597 and 97598 and is not separately reimbursed.

## Authorization Requirements for Wound Debridement

Prior authorization is required for non-emergent wound debridement procedure codes 11042, 11043, and 11044. A request for prior authorization must be submitted before the procedure is performed.

Prior authorization requests must be submitted to the Special Medical Prior Authorization (SMPA) department as follows:

- **Paper:** Providers must fax or mail the completed Special Medical Prior Authorization (SMPA) Request Form to the SMPA department, and retain a copy of the signed and dated form in the client’s medical record at the provider’s place of business. Requests may be faxed or mailed to:

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

- **Electronic:** Providers must complete the prior authorization requirements through any approved electronic method and retain a copy of the signed and dated SMPA Request Form in the client's medical record at the provider's place of business.

When required, the requests must include the physician's original signature and the date signed. Stamped or computerized signatures and dates are not accepted. Without this information, requests will be considered incomplete.

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 requesting provider may be asked for additional information to clarify or complete a request for the equipment/supply requested.

Requests for prior authorization for wound debridement procedure codes 11042, 11043, and 11044 must include the following documentation:

- Location of the wound
- Characteristics of the wound, including:
  - Dimensions (diameter and depth)
  - Drainage (amount and type)
  - Related signs and symptoms (swelling, pain, inflammation)
  - Presence of necrotic tissue/slough
- Wound care treatment plan

For procedure codes 11043 and 11044, at least one of the following conditions must be present and documented:

- Stage III or IV wounds
- Venous or arterial insufficiency ulcers
- Dehisced wounds or wounds with exposed hardware or bone
- Neuropathic ulcers
- Complications of surgically created or traumatic wound where accelerated granulation therapy is necessary but cannot be achieved by other available topical wound treatment

Wound debridement procedure codes 11042, 11043, and 11044 are not appropriate and will not be approved for the following:

- Washing bacteria or fungal debris from the feet
- Paring or cutting of corns or calluses
- Incision and drainage of an abscess
- Trimming or debridement of nails, or avulsion of nail plates
- Acne surgery
- Destruction of warts
- Burn debridement

Retroactive authorization is required for wound debridement procedure codes 11042, 11043, and 11044 that are performed on an urgent or emergent basis. The provider must submit a request for retroactive authorization within 14 calendar days, beginning the day after the procedure is performed.

The unspecified skin substitute procedure code Q4100 requires prior authorization.

When requesting prior authorization for procedure code Q4100, providers must submit the following information with the request:

- The client’s diagnosis
- Characteristics of the wound, including:
  - Location
  - Dimensions (diameter and depth)
  - Drainage (amount and type)
  - Related signs and symptoms (swelling, pain, inflammation)
  - Presence of necrotic tissue/slough
- Medical records that indicate prior treatment for the diagnosis, the medical necessity of the requested skin substitute, and the wound care treatment plan
- A clear, concise description of the skin substitute to be applied and the reason for recommending this particular item
- A Current Procedural Terminology (CPT) or HCPCS procedure code that is comparable to the requested procedure
- Documentation that demonstrates that the requested procedure is not investigational or experimental
- The place of service in which the requested procedure will be performed
- The physician’s intended fee for the requested procedure

Debridement of partial-thickness burns (procedure codes 16020, 16025, or 16030) do not require prior authorization. These services may be rendered by physician and qualified non-physician providers.

## Dressings and Metabolically Active Skin Equivalents

Wound dressings may include wet and dry dressings. Dressings applied to the wound are considered part of the service for wound debridement.

Metabolically active skin equivalents used in wound care may be considered separate benefits, in addition to the wound debridement procedure.

The following procedure codes are a benefit for metabolically active skin equivalents:

Procedure Codes									
C9250	Q4100	Q4101	Q4102	Q4103	Q4104	Q4105	Q4106	Q4107	Q4108
Q4110	Q4111	Q4112	Q4113	Q4114	Q4115	Q4116	Q4119	Q4120	Q4121

All metabolically active skin equivalent procedure codes may be reimbursed to physician, NP, CNS, and PA providers in the office setting, or to hospital providers in the outpatient setting; however, procedure code Q4100 may be reimbursed to physician, NP, CNS, and PA providers in the office setting only.

The following metabolically active skin equivalent procedure codes are considered part of the debridement performed at an ambulatory surgical center (ASC) and are not separately reimbursed to the ASC:

Procedure Codes									
C9250	Q4100	Q4101	Q4102	Q4103	Q4104	Q4105	Q4106	Q4107	Q4108
Q4109	Q4110	Q4111	Q4115	Q4116					

Metabolically active skin equivalents used in wound care are not reimbursed in the home setting.

## Compression

Compression performed as a part of wound care management is a benefit and may be reimbursed when billed with procedure code 29580.

## Whirlpool for Burns

Whirlpool may be a benefit when used as first-line wound care therapy for the treatment of burn wounds.

## Second-Line Wound Care Therapy

Second-line wound care therapy is limited to chronic stage III or IV pressure ulcers and may be reimbursed only after first-line therapy has been tried for at least 30 days without measurable signs of improved healing.

Second-line wound care therapy includes the following:

- Whirlpool
- Irrigation, including pulsatile jet irrigation

## Whirlpool

Whirlpool is a nonselective hydrotherapy used in the second-line treatment of chronic wounds that may be used in combination with other therapeutic treatments. Whirlpool generates water movement, which produces massage of body areas that impacts surface circulation and loosens nonviable tissue.

## Pulsatile-Jet Irrigation

Pulsatile-jet irrigation will be a benefit for the treatment of stage III or IV wounds when other forms of treatment have failed. Removal of devitalized tissue using pulsatile-jet irrigation may be reimbursed when claims are submitted for procedure code 97597 or 97598.

## Documentation Requirements

For all wound care management services, documentation that supports the medical necessity of the service must be maintained in the client's medical records, including the following information:

- Accurate diagnostic information that pertains to the underlying diagnosis and condition as well as any other medical diagnoses and conditions, which include the client's overall health status.
- Appropriate medical history related to the current wound, including the following:
  - Wound measurements, which includes length, width, and depth, any tunneling or undermining
  - Wound color, drainage (type and amount), and odor, if present
  - The prescribed wound care regimen, which includes frequency, duration, and supplies needed
  - Treatment for infection, if present

- All previous wound care therapy regimens, if appropriate
- The client's use of a pressure-reducing support surface, mattress, or cushion, when appropriate

Documentation maintained in the client's medical record must support the level of debridement service provided.

Fewer than five surgical debridements that involve removal of muscle or bone are typically required for management of most wounds. Documentation that is maintained in the client's medical record must support the number of debridements involving muscle or bone that are performed.

The client's medical record must include documentation that wound treatments with metabolically active skin equivalents or skin substitutes are accompanied by appropriate adjunctive measures, and must identify the adjunctive therapies being provided to the client as part of the wound treatment regimen.

## Noncovered Services

The following services are not a benefit of Texas Medicaid:

- Infrared therapy.
- Ultraviolet therapy.
- Topical hyperbaric oxygen therapy.
- Low-energy ultrasound wound cleanser (MIST therapy).
- Services that are submitted as debridement but do not include the removal of devitalized tissue. Examples include removal of non-tissue integrated fibrin exudates, crusts, biofilms, or other materials from a wound, without the removal of tissue.
- Electrical stimulation and electromagnetic therapy.



## Inpatient Claims to Be Reviewed for Spell-of-Illness Limitation

Texas Medicaid is conducting a utilization review of inpatient claims with dates of service from November 17, 2009, through October 1, 2011, to determine whether the claims were paid outside of the spell-of-illness limitation, which is 30 days of inpatient hospital care. Affected inpatient hospital claims that are found to have been paid in excess of the spell-of-illness limitation will be retroactively denied or cut back. Denials and cutbacks will appear as claim adjustments on R&S Reports.

For information about the spell-of-illness limitation and exceptions to it, providers can refer to the 2011 *Texas Medicaid Provider Procedures Manual, Vol. 1, General Information*, subsection 8.1.2, "Texas Medicaid Benefits by Program" or the 2011 *Texas Medicaid Provider Procedures Manual, Hospital Services Handbook*, subsection 2.3.2, "Inpatient Benefits and Limitations." ■

## Incontinence Supplies Benefits Have Changed for CCP and Home Health Services

Effective for dates of service on or after January 1, 2012, the incontinence supplies benefit has changed for the Comprehensive Care Program (CCP) and home health services.

Skin sealants, protectants, moisturizers, and ointments (procedure code A6250) are a benefit of Texas Medicaid for the following clients with documented incontinence-associated dermatitis:

- CCP clients who are 3 years of age and younger with documentation of medical necessity and prior authorization
- Home health services clients who are 4 years of age and older without prior authorization up to the stated quantity limitation

**Note:** *Skin sealants, protectants, moisturizers, 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 – Small area of skin breakdown (less than 20 cm<sup>2</sup>) with mild redness (blotchy and non-uniform) and mild erosion involving the epidermis only.
- Category 2 – Moderate area of skin breakdown (20 cm<sup>2</sup> through 50 cm<sup>2</sup>) 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 – Large area of skin breakdown (greater than 50 cm<sup>2</sup>) 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 – Large area of skin breakdown (greater than 50 cm<sup>2</sup>) 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:

Dermatitis Category	Procedure Code	Modifier	Benefit Limitation
<b>CCP</b>			
1 or 2	A6250	UA	Up to 2 containers (no less than 4 ounces per container) of skin sealants, protectants, moisturizers, and ointments per month may be considered with prior authorization.
3 or 4	A6250	None	Skin sealants, protectants, moisturizers, and ointments may be considered with prior authorization and documentation of medical necessity.

<b>Dermatitis Category</b>	<b>Procedure Code</b>	<b>Modifier</b>	<b>Benefit Limitation</b>
<b>Home Health Services</b>			
1 or 2	A6250	UA	Up to 2 containers (no less than 4 ounces per container) of skin sealants, protectants, moisturizers, and ointments per month may be considered without prior authorization. This is also limited to 12 containers per year.
3 or 4	A6250	None	Skin sealants, protectants, moisturizers, and ointments may be considered with prior authorization and documentation of medical necessity.

Providers should submit requests for procedure code A6250 on the following:

- For CCP clients – CCP Prior Authorization Request Form or electronic equivalent along with documentation of medical necessity.
- For home health services clients – Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form or electronic equivalent along with documentation of medical necessity for categories 3 or 4 incontinence-related dermatitis or for quantities exceeding the benefit limitation for category 1 or 2.



## Tobacco Cessation Counseling is a Benefit of Texas Medicaid

Effective for dates of services on or after January 1, 2012, tobacco use cessation counseling is a benefit of Texas Medicaid for pregnant clients who are 10 through 55 years of age.

Procedure codes 99406 and 99407 are a benefit when services are performed in the office, home, inpatient hospital, or outpatient hospital setting by an NP, CNS, PA, physician, or CNM provider. Both procedure codes are restricted to diagnosis codes 64900, 64901, 64902, 64903, and 64904.

The following reimbursement rates apply for procedure codes 99406 and 99407:

<b>Procedure Code</b>	<b>Age Range</b>	<b>Relative Value Unit 1/1/2012</b>	<b>Conversion Factor 1/1/2012</b>	<b>Base Fee 1/1/2012</b>	<b>Percent Reduction 1/1/2012</b>	<b>Adjusted** Fee 1/1/2012</b>
99406	0-20	0.41	\$28.640	\$11.74	2%	\$11.51
99406	21-999	0.41	\$27.276	\$11.18	2%	\$10.96
99407	0-20	0.80	\$28.640	\$22.91	2%	\$22.45
99407	21-999	0.80	\$27.276	\$21.82	2%	\$21.38

\*\*Adjusted fees reflect mandated reductions

Note: The age ranges shown in this table do not reflect the actual age limitations (as stated above) for these procedure codes.

Only one procedure code, either 99406 or 99407, will be reimbursed per day, any provider.

Procedure codes 99406 and 99407 are limited to a combined total of 8 visits per pregnancy, any provider. ■

## Rate Reduction Applied to Diabetic Services Procedure Codes A4253 and A4259 Has Changed

Effective for dates of service on or after January 1, 2012, the rate reduction applied to diabetic services procedure codes A4253 and A4259 have changed for Texas Medicaid.

For dates of service on or after January 1, 2012, procedure codes A4253 and A4259 are subject to an eight-percent reduction. Previously, these procedure codes were subject to an 18.70-percent reduction. The adjusted fees reflect mandated percent reductions for the effective dates.

The following table shows the affect of this change.

Procedure Code	Age Range	Medicaid Fee Effective Through 12/31/11	Reduction Effective Through 12/31/11	Adjusted Fee Effective Through 12/31/11	Reduction Effective 1/1/12	Adjusted Fee Effective 1/1/12
A4253	0-999	\$30.74	18.70%	\$24.99	8.00%	\$28.28
A4259	0-999	\$12.06	18.70%	\$9.80	8.00%	\$11.10

■ ■ ■

## Benefit Criteria Have Changed for Some Radiology Diagnostic Imaging Services

Effective for dates of service on or after January 1, 2012, radiology diagnostic imaging procedure codes 75956, 75957, 75958, and 75959 are a benefit for Texas Medicaid clients of any age.

The professional component for procedure codes 75956, 75957, 75958, and 75959 are reimbursed as follows:



Procedure Code	Age Range	Relative Value Unit 1/1/2012	Conversion Factor 1/1/2012	Fee 1/1/2012	Percent Reduction 1/1/2012	**Adjusted Fee 1/1/2012
75956	0-20	10.11	28.64	\$289.55	2%	\$286.76
75956	21-999	10.11	27.276	\$275.76	2%	\$270.24
75957	0-20	10.11	28.64	\$289.55	2%	\$286.76
75957	21-999	10.11	27.276	\$275.76	2%	\$270.24
75958	0-20	5.76	28.64	\$164.97	2%	\$161.67
75958	21-999	5.76	27.276	\$157.11	2%	\$153.97
75959	0-20	5.06	28.64	\$144.92	2%	\$142.02
75959	0-999	5.06	27.276	\$138.02	2%	\$135.26

\*\*Adjusted fees reflect mandated reductions

■ ■ ■

## Reimbursement Rates Have Changed for Some Procedure Codes

Effective for dates of service on or after January 1, 2012, reimbursement rates for the following services have changed for Texas Medicaid:

- Diagnostic Radiology
- Musculoskeletal
- Portable X-Ray (R Codes)
- Radiopharmaceuticals
- Respiratory
- Sign Language (T Codes)
- Telehealth and irrigation Solution (Q Codes)

The age ranges that are shown for procedure codes may not reflect the actual age limitations that are associated with the procedure codes.

To obtain specific age limitations for individual procedure codes, providers can search the materials available on the TMHP website at [www.tmhp.com](http://www.tmhp.com) (current provider manuals, bulletins, and website articles) by searching for the procedure code in the OFL and then clicking the **View** button for the procedure code.

Providers can also refer to the *Current Procedural Terminology* coding manual, or *Healthcare Common Procedure Coding System* (HCPCS) coding manual. ■

## Reimbursement Rate Change for Occupational, Physical, and Speech Therapy Services Postponed

The reimbursement rate changes for physical, occupational, and speech therapy services that were proposed at the November 21, 2011, rate hearing will not be implemented for dates of service on or after January 1, 2012. Services that are performed by comprehensive outpatient rehabilitation facility (CORF), outpatient rehabilitation facility (ORF), independent practitioner (including a provider of Early Childhood Intervention [ECI] therapy), home health agency, and nursing facility providers are affected.

Providers should monitor the HHSC website at [www.hhsc.state.tx.us/news/meetings.asp](http://www.hhsc.state.tx.us/news/meetings.asp) for information related to a public rate hearing for these reimbursement rates, which will be held at a future date. ■

## Texas Medicaid Claims Reprocessing

The following claims issues have been identified. All affected claims will be reprocessed, and payments will be adjusted accordingly. When these claims are reprocessed, providers may receive additional payment or payments that were made in error may be deducted from future payments (i.e., recouped) which will be reflected on R&S Reports. No action on the part of the provider is necessary.

### Add-on Prolonged Extracorporeal Circulation Claims Reprocessing

TMHP has identified an issue that impacts claims with procedure code 33961 and dates of service on or before December 31, 2011. Claims that were submitted with this add-on procedure code for prolonged extracorporeal circulation may have been denied incorrectly by Texas Medicaid and may continued to be denied until the issue is resolved.

Claims that may have been denied incorrectly will have one of the following EOB denial codes:

- 00164 -These services are not in accordance with medical policy
- 05114 - Primary code missing or denied for add on code billed

When affected claims that were submitted within the past 24 months are reprocessed, providers may receive additional payment, which will be reflected on R&S Reports.

### Add-on Surgery Services Claims Reprocessing

TMHP has identified an issue that affects claims for add-on surgery services that were submitted without the appropriate primary procedure codes. These claims may have been reimbursed or denied incorrectly by Texas Medicaid. Affected claims that were submitted from July 1, 2009, through December 1, 2010, may be reprocessed. When claims that were denied incorrectly are reprocessed, providers may receive additional payment; however, payments made in error will be deducted from future payments (i.e., recouped). All adjustments will be reflected on future R&S Reports.

**Note:** *Claims that were submitted more than 24 months from the date of reprocessing will not be reprocessed for additional payment.*

**Reminder:** The Patient Protection and Affordable Care Act mandates that all claims submitted on or after October 1, 2010, must be filed in accordance with National Correct Coding Initiative (NCCI) guidelines. All claims submissions for add-on surgery services must be accompanied by the appropriate primary code. Add-on surgery services will be denied if the corresponding primary procedure code is not reimbursed for the same date of service.

Providers may refer to the CMS website at [www.cms.gov/NationalCorrectCodInitEd/](http://www.cms.gov/NationalCorrectCodInitEd/) for more information about NCCI coding guidelines and a list of surgical add-on procedure codes.

### Clinical Laboratory Services Procedure Code 81007

TMHP has identified an issue that impacts claims that were submitted by hospitals for outpatient clients for clinical laboratory services procedure code 81007. Affected claims that were processed from April 1, 2010, through December 13, 2011, were reimbursed using an incorrect methodology. These claims were reimbursed at a percentage of the billed amount, but for outpatient claims, procedure code 81007 should be reimbursed at a fixed rate equivalent to the maximum fee for physician providers.

## Claims for Some Laboratory Services to Be Reprocessed

TMHP has identified an issue that impacts claims for the following laboratory services:

Procedure Codes									
84431	85013	85018	86001	86003	86005	87205	87797	87900	87901
87903	87906	88237	88239						

Medicaid or CSHCN claims that were submitted with a date of service from August 27, 2011, through November 2, 2011, may have been incorrectly denied payment.

## Some Laparoscopic Surgery Services Procedure Codes Added as Benefits of Texas Medicaid and the CSHCN Services Program

Effective November 17, 2011, for dates of service on or after November 18, 2009, laparoscopic surgery services procedure codes 58570, 58571, 58572, and 58573 are benefits of Texas Medicaid when services are rendered in the outpatient hospital setting.

Claims for these procedure codes with dates of service from November 18, 2009, through November 17, 2011, may have been incorrectly denied payment by Texas Medicaid.

## Medicare Part C Crossover Claims Reprocessing

TMHP has identified an issue that affects Medicare Part C crossover claims. Claims that were submitted with dates of service from January 1, 2008, through March 24, 2011, may have been paid incorrectly by Texas Medicaid due to issues with eligibility information.

## Outpatient Reprocessing Claims for Procedure Code 80050

TMHP has identified an issue that impacts outpatient claims that were submitted with procedure code 80050 and dates of service from April 1, 2011, through August 31, 2011. These claims may have been paid at an incorrect rate by Texas Medicaid.

## Claims Submitted for Nurse Practitioner, Clinical Nurse Specialist, and Physician Assistant Providers to Be Reprocessed

TMHP has identified an issue that impacts claims that were submitted for nurse practitioner, clinical nurse specialist, and physician assistant providers from December 19, 2011, through December 23, 2011. These claims were not audited for NCCI compliance and require additional adjudication.

For claims that were paid but not audited for NCCI compliance, one of the following EOB messages will appear on the R&S Report to indicate that the claim requires further review, which could result in recoupment at a later date:

EOB Code	Message
01187	Claim pending further review. No action on the part of the provider is necessary.
01188	Unable to validate correct coding compliance. Claim may be adjusted at a later time.
01189	Unable to validate correct coding compliance. Claim may be adjusted at a later time.

Affected claims will be reprocessed and audited for NCCI compliance. When these claims are reprocessed and the NCCI guidelines are applied, claims that were paid correctly will be unaffected, but any payments that were made in error will be recouped. Payments and deductions will be reflected on R&S Reports.

## Radiology Services Claims Reprocessing

TMHP has identified an issue that impacts claims that were submitted prior to November 17, 2011, for radiology services procedure codes 75565, 75571, 75572, 75573, and 75574. These claims may have been denied incorrectly by Texas Medicaid or the CSHCN Services Program as being included in another procedure.

## Claims Reprocessing for Some Wheeled Mobility Aids Procedure Codes

TMHP has identified an issue that impacts claims submitted with the following wheeled Mobility Aids procedure codes for dates of service on or after September 1, 2011:

TOS	Procedure Code	TOS	Procedure Code	TOS	Procedure Code	TOS	Procedure Code	TOS	Procedure Code
J	A9900	J	E0190	J	E0700	J	E0705	J	E0942
J	E0944	J	E0945	J	E0950	J	E0951	J	E0952
J	E0955	J	E0957	J	E0958	J	E0960	J	E0961
J	E0969	J	E0970	J	E0971	J	E0973	J	E0974
J	E0978	J	E0980	J	E0981	J	E0982	J	E0992
J	E0994	J	E0995	J	E1015	J	E1016	J	E1017
J	E1018	J/L	E1020	J	E1028	J	E1029	J/L	E1050
J/L	E1060	J/L	E1070	J/L	E1083	J/L	E1084	J/L	E1085
J/L	E1086	J/L	E1087	J/L	E1088	J/L	E1089	J/L	E1090
J/L	E1093	J/L	E1100	J/L	E1110	J/L	E1130	J/L	E1150
J/L	E1160	J/L	E1170	J/L	E1171	J/L	E1172	J/L	E1180
J/L	E1190	J/L	E1195	J/L	E1200	J/L	E1240	J/L	E1250
J/L	E1260	J/L	E1270	J/L	E1280	J/L	E1399	J	E2205
J	E2206	J/L	E2207	J/L	E2208	J/L	E2209	J	E2210
J	E2211	J	E2212	J	E2213	J	E2214	J	E2215
J	E2216	J	E2217	J	E2218	J	E2219	J	E2220
J	E2221	J	E2222	J	E2224	J	E2225	J	E2226
J	E2227	J	E2228	J	E2326	J	E2361	J	E2363
J	E2366	J	E2368	J	E2369	J	E2370	J	E2371
J	E2381	J	E2382	J	E2383	J	E2384	J	E2385
J	E2386	J	E2387	J	E2388	J	E2389	J	E2390
J	E2391	J	E2392	J	E2393	J	E2394	J	E2395
J	E2396	J	E2601	J	E2602	J	E2603	J	E2604
J	E2605	J	E2606	J	E2607	J	E2608	J	E2611
J	E2612	J	E2613	J	E2614	J	E2615	J	E2616
J	E2619	J	E2622	J	E2623	J	E2624	J	E2625
J	K0108	J	K0733	9	K0739				

TOS = Type of service, TOS J = Durable medical equipment (DME) purchase new, TOS L = DME rental, TOS 9 = Other/durable medical equipment

Claims that were denied for services rendered during that timeframe that are related to a mobility aid will be reprocessed. When the claims are reprocessed, providers may receive additional payment, which will be reflected on R&S Reports. ■

## Updates to Previously Published Information

The following are updates and corrections to articles that were published in previous bulletins or on the TMHP website at [www.tmhp.com](http://www.tmhp.com) as either banner messages or web articles.

### Clarification of “Physician Assistants and Certified Nurse Midwives Must Submit Supervising Physician Information to TMHP”

This is a clarification to an article titled “Physician Assistants and Certified Nurse Midwives Must Submit Supervising Physician Information to TMHP,” which was published on the TMHP website at [www.tmhp.com](http://www.tmhp.com) on October 28, 2011.

The clarification is that PAs are required to submit information about their supervising physicians, and CNMs are required to submit information about the physicians with whom they have arrangements for referrals and consultations. The requirement for CNMs is based on TAC Section 1 §354.1252 Conditions for Participation.

PAs must submit information about their supervising physicians as follows:

- PAs who are already enrolled in Texas Medicaid must submit their supervising physician information in the “Other” field on the Provider Information Change (PIC) form.
- Newly enrolling physician assistants must submit the information in the “Supervising or Referring/Consulting Physician” fields in Provider Enrollment on the Portal (PEP) or on the paper enrollment application.

CNM providers must submit their referring and consulting physician information as follows:

- CNMs who are already enrolled in Texas Medicaid must submit their referring and consulting physician information in the “Other” field on the Provider Information Change (PIC) form.
- Newly enrolling CNMs must submit their referring and consulting physician information in the “Supervising or Referring/Consulting Physician” fields in PEP or on the paper enrollment application.

**Important:** TMHP must receive the supervising physician or referring/consulting physician information no later than March 18, 2012. Beginning March 19, 2012, payments to a physician assistant or CNM provider will be held until the required information is received.



### Clarification of “TMHP Will Reprocess Some National Drug Code (NDC) Claims”

This is a clarification of an article titled “TMHP Will Reprocess Some National Drug Code (NDC) Claims,” which was published on December 3, 2010, on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The article included procedure code and NDC combinations but did not specify whether they may have been denied or reimbursed in error.

The following table shows which procedure codes and NDC combinations may have been denied or reimbursed in error.

Procedure Code	NDC			
<b>Claims That May Have Been Denied in Error</b>				
J1626	00703787103	00703797301	64679066102	66758003501
	66758003601	66758003702		
J1885	00074379601			
J2405	00143977106	00173046100		
J2550	00143986822	00143986922	00409231202	00591315754
	00591315854	66758060119	66860009803	66860009903
	67457015210			
J3370	00074433201			
<b>Claims That May Have Been Reimbursed in Error</b>				
J0696	00004196501	00004196505	00004200278	00004200378
J1170	00074233211	00074233311	00074233326	00074233411
	00074241421	00074245311		
J1566	00944047172	00944047180		
J2430	00703408511			
J3010	58298052502			
J7190	00944293503			
J7192	00026037220	00026037230		
J9000	10019092001			
J9040	00703315491			
J9045	00015321430	00015323011	00703327601	00703327801
	50111096576	50111096676		
J9060	00015322022	00015322122	10019091002	
J9178	00591346983			
J9190	00187395364			
J9206	00591318902	10518010310	10518010311	
J9217	00300210801	00300244001	00300334601	00300364201
	00300366301	00300368301		
J9265	00015347530	00015347630	00015347911	00172375377
	00172375473	10518010207	10518010209	55390051420
	55390051450			
J9390	00173065601	00173065644		

Affected claims have already been reprocessed.

For the complete listing of all valid NDCs for Healthcare Common Procedure Coding System (HCPCS) procedure codes (The Noridian NDC-to-HCPCS crosswalk) providers can visit the Noridian website at [www.dmepdac.com/resources/index.html](http://www.dmepdac.com/resources/index.html).

## **Correction to “July 2011 Benefit Changes for CCP and Home Health Mobility Aids Services”**

This is a correction to the article titled “July 2011 Benefit Changes for CCP and Home Health Mobility Aids Services,” which was published on June 1, 2011, on the TMHP website at [www.tmhp.com](http://www.tmhp.com). The article incorrectly stated that in addition to the up to one hour (four units) which may be authorized for a qualified rehabilitation professional (QRP) to participate in a seating assessment, extra time may be provided with documentation of medical necessity.

The correct information is that up to one hour (four units) may be authorized for a QRP to participate in a seating assessment. No extra time will be authorized for the seating assessment based on medically necessity.

**Reminder:** The fitting of a manual or powered wheeled mobility device requires prior authorization. Prior authorization may be issued for the QRP in 15-minute increments for up to two hours (eight units). Up to one additional hour (four units) may be authorized for the fitting with documentation of medical necessity showing that the fitting of three or more major systems or additional client training is required for such systems. Major systems can include, but are not limited to, the following:

- Complete, complex seating system (planar system with trunk supports and hip supports or abductor or custom contoured seating system such as a molded system).
- Off-the-shelf seat and back cushions do not constitute a complex seating system.
- Alternative drive controls, such as a head array or mini-proportional system.
- Additional specialty control features, such as infrared access.
- Power positioning features, such as power tilt or power recline.
- Specific-purpose specialty features, such as power seat elevation systems or power elevating leg rests.

The correct authorization number must be on the claim at the time of submission.

All modifications and adjustments to a wheeled mobility system within the first six months of delivery are considered part of the purchase price and will not be reimbursed separately. This includes the associated QRP services for the seating assessment and fitting.

## **Correction to “Upcoming Reimbursement Rate Adjustments for Some Texas Medicaid Procedure Codes”**

This is a correction to an article titled “Upcoming Reimbursement Rate Adjustments for Some Texas Medicaid Procedure Codes,” which was published on November 22, 2011, on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The article incorrectly stated that the rate adjustments were effective for dates of service on or after January 1, 2011. The correct effective date is January 1, 2012.

## **Update to “Changes to Texas Medicaid Enrollment for Prosthetists and Orthotists Effective December 19, 2011”**

This is an update to the article titled “Changes to Texas Medicaid Enrollment for Prosthetists and Orthotists Effective December 19, 2011,” which was published on the TMHP website at [www.tmhp.com](http://www.tmhp.com) on October 28, 2011.

S.B. 874, 82nd Legislature, Regular Session, 2011, requires that HHSC establish and implement separate provider types for prosthetist and orthotist providers for purposes of enrollment and reimbursement in Texas Medicaid. Texas Medicaid currently enrolls orthotists and prosthetists as DME providers.

Effective December 16, 2011, the paper version of the Texas Medicaid Provider Enrollment Application and PEP will be updated to allow orthotists and prosthetists to enroll in Texas Medicaid specifically as an orthotist or as a prosthetist.

Providers who are currently enrolled in Texas Medicaid as durable medical equipment (DME) providers but are licensed as an orthotist or prosthetist may complete a [deeming form](#) to enroll as an orthotist or prosthetist in Texas Medicaid. Providers will have until April 30, 2012, to submit the deeming form to TMHP. Orthotist and prosthetist providers not currently enrolled in Texas Medicaid must complete the enrollment application either on paper or using PEP.

Orthotic and prosthetic services rendered for dates of service through May 31, 2012, will continue to be reimbursed only to DME providers. For dates of service on or after June 1, 2012, orthotic and prosthetic services will be reimbursed only to providers who are enrolled as an orthotist or prosthetist. These services will no longer be reimbursed to DME providers after May 31, 2012.

## **Update to “Ultrasound Procedure Codes 76881 and 76882 Submitted by Podiatrists”**

This is an update to an article titled “Ultrasound Procedure Codes 76881 and 76882 Submitted by Podiatrists,” which was published in the November/December 2011 *Texas Medicaid Bulletin*, No. 238, and on the TMHP website at [www.tmhp.com](http://www.tmhp.com) on July 22, 2011. The article states that claims for procedure code 76882 that were rendered by podiatrist providers with dates of service from January 1, 2011, through July 6, 2011, may have been incorrectly denied payment and would be reprocessed.

The dates of service have changed for procedure code 76882. The impacted claims are for dates of service from January 1, 2011, through November 10, 2011. No action by the affected providers is necessary.

## **Update to the 2011 *Texas Medicaid Provider Procedures Manual***

### ***Clarification to Change of Ownership Process***

This is a clarification to the 2011 *Texas Medicaid Provider Procedures Manual*, Vol. 1, *General Information*, subsection 1.3 “Provider Reenrollment,” concerning the change of ownership process for Texas Medicaid providers.

The new owner must do the following:

- Obtain recertification as a Title XVIII (Medicare) facility under the new ownership.
- Provide TMHP with a copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners in 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).
- Provide a separate change of ownership and Texas Medicaid provider enrollment application for all of the provider identifiers affected by the change of ownership.
- Submit any new enrollment application relating to a change in ownership to TMHP Provider Enrollment within 10 calendar days of the change.

**Note:** *When the Change of Ownership has been processed, the original TPI used by the provider to bill claims will be deactivated. At the time of deactivation, the provider loses the ability to download R&S Reports from the TMHP portal as well as the ability to verify client eligibility online. Claims status inquiries through the TMHP portal are also unavailable.*

Once the Change of Ownership has been processed, the provider must call the contact center to check on client eligibility and the status of claims. Paper R&S Reports can be printed by the TMHP Contact Center, and delivered to providers up to 30 days from the date the Change of Ownership is processed.

**Important:** Providers must adhere to claim filing deadlines throughout the enrollment process. Providers should submit claims without a provider identifier until notified by TMHP of final enrollment determination. Claims filing deadlines for services rendered to Texas Medicaid clients who do not have Medicare benefits are 95 days from the date of service for in-state providers and 365 days from the date of service for out-of-state providers.

### **Update to Geneticists Section**

This is an update to the 2011 *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 5.2, “Geneticists Services, Benefits, Limitations, and Prior Authorization.”

The information about pharmacogenetics has been updated as follows:

Pharmacogenetics encompasses the use of information encoded in DNA to help predict responses to medicines and thereby enhance the effectiveness and safety of medicines for individual clients. Testing for drug efficacy is not a benefit of Texas Medicaid, except as outlined in other sections of the *Texas Medicaid Provider Procedures Manual*.

### **Update to RSV Prophylaxis Prior Authorization Requirements**

This is an update to the 2011 *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 8.2.65.2, “[Respiratory Syncytial Virus (RSV) Prophylaxis] Prior Authorization Requirements.”

The following changes have been made to this subsection:

- The diagnosis code tables have been removed. This is not a change to prior authorization requirements, which are restricted to specific covered indications and not diagnoses.
- The distinction between cyanotic and acyanotic heart disease has been removed from the prior authorization requirements.

The following is the complete, updated text that is affected by this change:

Providers may receive prior authorization for Palivizumab on behalf of Medicaid clients who are birth through 23 months of age, and who have congenital heart disease, when the submitted documentation demonstrates at least one of the following:

- The presence of moderate to severe pulmonary hypertension
- Active treatment for and diagnosis of hemodynamically-significant heart disease, including both of the following documentation requirements:
  - Active treatment for hemodynamically-significant heart disease within the six months preceding the start of the RSV season (i.e., treatment dates between April 1 and September 30) consisting of digitalis, diuretics, or supplemental oxygen
  - A diagnosis code that is consistent with hemodynamically-significant congenital heart disease (i.e., congenital anatomical cardiac defects or cardiomyopathies of any etiology)

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Providers may receive prior authorization for Palivizumab on behalf of Medicaid clients who are birth through 23 months of age, and who have underlying lung disease, if the submitted documentation demonstrates the following:

- Active treatment for lung disease within the six months preceding the start of the RSV season (i.e., treatment dates between April 1 and September 30) consisting of one of the following:
  - Corticosteroids (systemic or inhaled), bronchodilators, diuretics, or supplemental oxygen therapy
  - Mechanical ventilation
- One of the following diagnoses of significant lung disease:
  - Chronic respiratory failure
  - Chronic respiratory disease arising in the perinatal period
  - Congenital bronchiectasis
  - Diaphragmatic defects
  - Congenital cystic lung disease
  - Congenital agenesis, hypoplasia, and dysplasia of lung
  - Other respiratory diagnoses with supportive documentation of medical necessity

Providers may receive prior authorization for Palivizumab on behalf of Medicaid clients who are birth through 11 months of age when documentation includes at least one of the following:

- A diagnosis code that indicates the infant was born at 28 weeks, 6 days estimated gestational age or earlier
- A diagnosis code that indicates the infant was born at less than 35 weeks estimated gestational age and documentation of one of the following:
  - Neuromuscular disease
  - Significant congenital anomalies of the airway expected to compromise respiratory reserve

Providers may receive prior authorization for Palivizumab on behalf of Medicaid clients who are birth through 5 months of age when documentation includes at least one of the following:

- A diagnosis code that indicates the infant was born at 29 weeks through 31 weeks, 6 days estimated gestational age
- A diagnosis code that indicates the infant was born at 32 weeks through 34 weeks, 6 days estimated gestational age and documentation of at least two of the following in the client's medical record:
  - Direct exposure to tobacco smoke or documented environmental air pollutants
  - Regular childcare attendance
  - Siblings who attend childcare or school outside of the home
- A diagnosis code that indicates the infant was born at any gestational age with documentation of cystic fibrosis

Providers may receive prior authorization for Palivizumab on behalf of Medicaid clients who are birth through 12 months of age and who have had a stem cell or solid organ transplant. ■

## FAMILY PLANNING PROVIDERS

## Family Planning Titles V, X & XX Program Changes Effective January 15, 2012

Effective for dates of service on or after January 15, 2012, all family planning funding was integrated into one funding source called the Department of State Health Services (DSHS) Family Planning Program. DSHS contractors no longer submit Title V or Title XX claims for payment.

The program will be referenced as “Title X” on all claims related documentation (Remittance and Status [R&S] Reports, 2017 Claim Form, TexMedConnect, etc.) until the name is officially changed to “DSHS Family Planning Program” at a later date. All claims must be filed as Title X until the name change has been completed. These claims no longer result in “informational only” encounters, but are processed as fee-for-service claims.

All DSHS Family Planning Program fee-for-service claims are subject to the limitations and reimbursement that were established for Title XX on or before January 14, 2012.

DSHS Family Planning Program providers must continue to provide services to established clients and to submit and appeal claims for client services even after the contract funding limit has been met. If providers choose to see new clients after the contract funding limit has been met claims must also be filed for these services. The claim status is “F” for Funds Gone when the contract funding limit has been met.

Providers can refer to the Online Fee Lookup (OFL) on the Texas Medicaid & Healthcare Partnership (TMHP) website at [www.tmhp.com](http://www.tmhp.com) for reimbursement rates.

For more information about the changes or DSHS Family Planning Program services, providers may refer to the information provided in the 2011 *Texas Medicaid Provider Procedures Manual* Subsection 4.3, “Services, Benefits, Limitations and Prior Authorization” of the *Gynecological and Reproductive Health, Obstetrics, and Family Planning Services Handbook (Vol. 2, Provider Handbooks)*.

The changes do not affect Title XIX benefits, limitations, and claims processing. ■

## Update to “Change to Family Planning Titles V and XX Office Visit Benefit Effective September 1, 2011”

This is an update to the article titled “Change to Family Planning Titles V and XX Office Visit Benefit Effective September 1, 2011,” which was published on the TMHP website at [www.tmhp.com](http://www.tmhp.com) on August 8, 2011. The article included the limitations for procedure code 99214 but did not mention that this procedure code requires an FP modifier to indicate family planning services. Claims submitted with procedure code 99214 for family planning services must include the FP modifier. ■

## MANAGED CARE PROVIDERS

# Coming Soon: TexMedConnect and the Electronic Data Interchange to Accept MCO and Dental Plan Claim Submissions for Routing to Appropriate Health or Dental Plan

Effective for dates of service on or after March 1, 2012, providers will be able to submit electronic claims to Texas Medicaid & Healthcare Partnership (TMHP) for services to Medicaid clients whose benefits are administered by a Medicaid managed care organization (MCO) or a Medicaid dental plan. TMHP will accept the claim submissions and forward the claims as necessary to the correct MCO/dental plan based on the client's eligibility on file.

Starting March 1, 2011, providers who have contracted with more than one MCO or dental plan, or who provide services to fee-for-service clients in addition to MCO or dental plan clients, will no longer need to separate their Medicaid fee-for-service, State of Texas Access Reform (STAR), STAR+PLUS, STAR Health, and dental plan claims for submission through different channels.

Providers can choose to continue to submit claims directly to the appropriate entity:

- The MCO for STAR, STAR+PLUS, or STAR Health clients
- The dental plan for dental clients
- TMHP for fee-for-service clients, carve-out services, or Medicare crossover claims

When submitting claims directly to an MCO or dental plan, providers must follow the guidelines established by the MCO or dental plan for claims submissions. Providers may refer to the PCCM homepage on the TMHP website at [www.tmhp.com](http://www.tmhp.com) for additional information about the managed care changes that will be effective March 2012, and the contact information for the Medicaid MCO and dental plans that will be in effect at that time.

## Exceptions

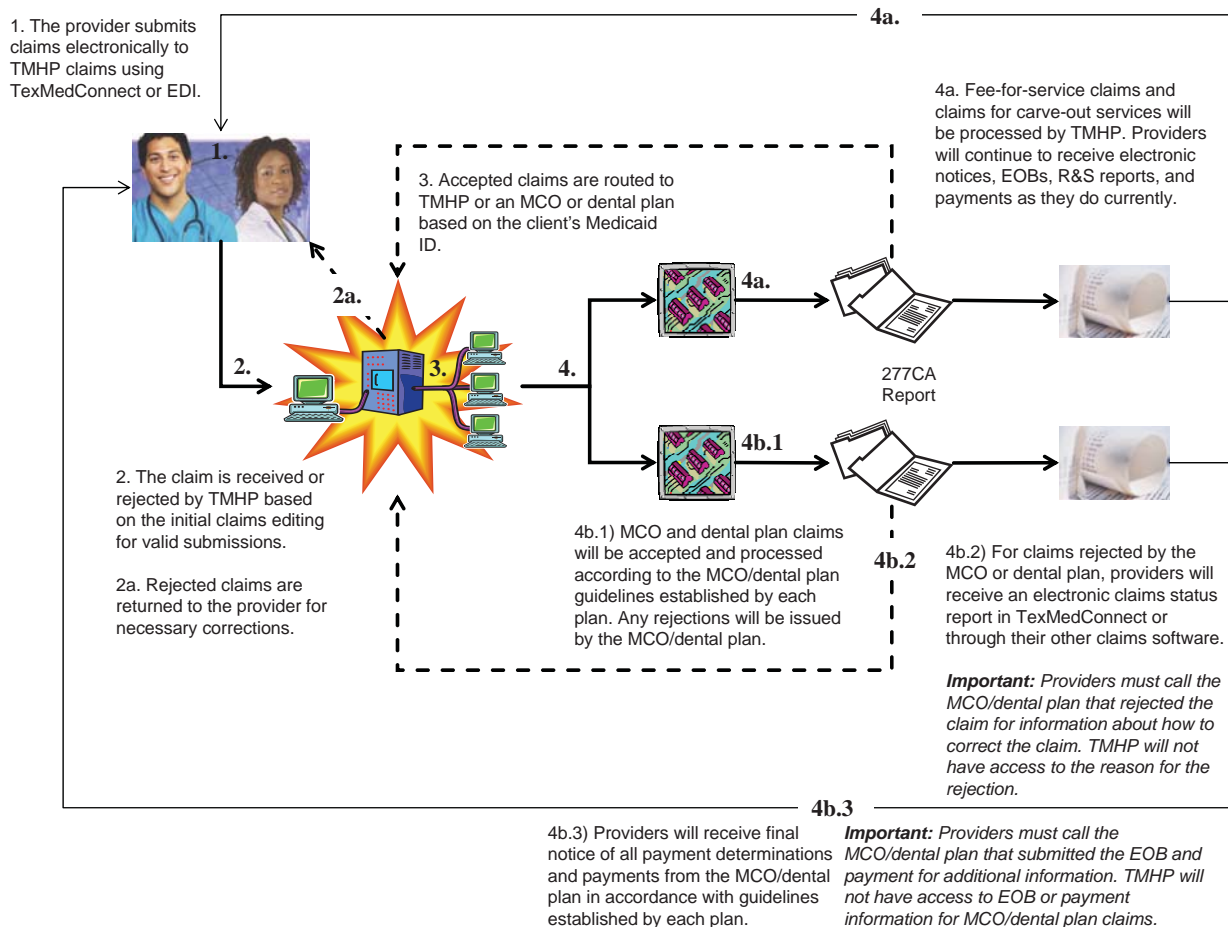
TMHP will not forward the following claims submissions, which must be submitted directly to the MCO or dental plan that administers the client's Medicaid managed care benefits:

- Paper claim forms
- Electronic submissions for:
  - Pharmacy
  - NorthSTAR
  - Children's Health Insurance Program (CHIP)
  - Long term care services

Medicare coinsurance and deductible claims (i.e., crossovers) for clients who have Medicare and Medicaid dual-eligibility must continue to be submitted to TMHP on paper if the claims were not originally crossed over from the Medicare Intermediary or the Coordination of Benefits Administrator (COBA).

## MCO and Dental Plan Claims Filing Using TexMedConnect or Through EDI

The following diagram provides an overview of the electronic claims submission process that will go into effect on March 1, 2012:



Using the new submission process, providers will submit electronic claims for services to MCO or dental plan clients as they would for any other Medicaid client using TexMedConnect or EDI. Providers can submit claims individually or in a batch. Batches can contain claims for fee-for-service and multiple MCO or dental plans.

Providers should be careful to submit the following services for the same client on separate claims:

- Carve-out services, which are rendered to MCO clients but processed by TMHP (Carve-out services will be listed in future articles.)
- Services that are processed by the MCO

Claims that contain both carve-out services and MCO services will be rejected.

After transmitting a claim, providers will receive a message that indicates whether the claim was transmitted successfully or unsuccessfully. The provider will be able to correct the submission and resubmit the claim until the transmission is successful.

Claims that have been transmitted successfully will be systematically routed to the appropriate entity based on the client's eligibility that is on file. Claims that are routed to an MCO or dental plan will be accepted or rejected by the MCO or dental plan as follows:

- If a claim is accepted by the MCO or dental plan, the provider will receive no more transmissions from TMHP about the claim. Notices for payment determinations and all payments will be sent to the provider by the MCO or dental plan according to their individual practices and procedures.
- If a claim is rejected by the MCO or dental plan, the provider will receive an electronic claim status report from TMHP. Providers will be able to correct the submission and submit the claim to TMHP until the claim is accepted by the MCO or dental plan.



**Important:** TMHP will not have access to the MCO or dental plan claims, benefits, or processes. Providers must call the client's MCO or dental plan which processed the claim for information about the MCO or dental plan EOB, claims payment or denial, claim rejection, how to correct a rejected claim, or any other questions about the MCO or dental plan claim guidelines and processes.

Providers will be able to use TexMedConnect or EDI to make changes to denied or rejected MCO and dental plan claims that were submitted to TMHP for routing to the appropriate entity. The resubmitted claims will follow the same processes as described above.

## Authorization Requests Not Affected

Authorization requests will continue to be handled by the entity that processes the claim:

- For services that are administered by a client's MCO or dental plan, authorization requests must be submitted directly to the MCO or dental plan following the guidelines established by each plan.
- For carve-out services and services to fee-for-service clients, authorization requests must be submitted to TMHP following the guidelines established by TMHP.

Providers can refer to the TMHP website for the contact information for contracted MCOs and dental plans.

More information will be provided in future articles. Providers should refer to the TMHP EDI web page periodically for updates. ■

## Clarification to “PCCM Outpatient Services will be Subject to Cost Report Settlements”

This is a clarification to an article titled “PCCM Outpatient Services will be Subject to Cost Report Settlements,” which was published on the TMHP website at [www.tmhp.com](http://www.tmhp.com) on August 6, 2010. The article indicated that the cost settlement would be determined by comparing the total Medicaid-allowable costs to the provider’s interim payments for Primary Care Case Management (PCCM) outpatient hospital services that were delivered during the reporting period. The clarification is that the interim payments used for the comparison will include PCCM outpatient hospital services that were delivered on or after September 1, 2010, through the end of the hospital reporting period.

Some hospitals have already received a notice of program reimbursement that reflects the cost settlement of its PCCM outpatient services. Cost-settled reports that span date of service September 1, 2010, will be reopened. The reopened PCCM outpatient cost settlement will be adjusted to reconcile costs and payments that are related only to PCCM services that were delivered on or after September 1, 2010. Cost-settlement amounts that have already been paid to or received from a hospital that are attributable to services delivered before September 1, 2010, will be reversed.

### The following is the complete, revised article:

Effective September 1, 2010, for hospital fiscal years that end on or after September 1, 2010, PCCM outpatient services are subject to cost report settlements.

PCCM outpatient services providers are not required to submit any additional forms or reports, because the Health and Human Services Commission (HHSC) has required providers to submit the necessary PCCM supplemental worksheets along with the Centers for Medicare & Medicaid Services (CMS) form number CMS-2552-96, “Cost Report for Electronic Filing of Hospitals,” for hospital cost reports that end on or after October 1, 2007. The PCCM supplemental worksheets include the Inpatient PCCM D-4 worksheet and the Outpatient PCCM D, Part V worksheet.

The interim cost report settlement process will be completed within six months of the date on which the TMHP Medicaid Audit Department receives the workable cost report. The cost settlement will be determined by comparing the Medicaid-allowable costs to the provider’s interim payments for PCCM outpatient hospital services with dates of service on or after September 1, 2010, through the end of the hospital’s reporting period. HHSC will then issue a notice of settlement that specifies the amount due to or from the PCCM outpatient hospital. ■



**Our State’s most  
Vulnerable  
kids need you!**

Help the children in your community who need it most. Enroll in the Children with Special Health Care Needs (CSHCN) Services Program today. Go to [www.dshs.state.tx.us/cshcn](http://www.dshs.state.tx.us/cshcn) to learn more about the program, then visit the TMHP website at [www.tmhp.com](http://www.tmhp.com) to enroll.

## THSTEPS DENTAL PROVIDERS

## Reimbursement Rate Change for Orthodontia Services Postponed

The reimbursement rate changes for orthodontia services that were proposed at the November 16, 2011, rate hearing will not be implemented for dates of service on or after January 1, 2012.

A future notification will be published when an implementation date has been set for the rate changes to become effective.

Providers should monitor the Texas Health and Human Services Commission (HHSC) website at [www.hhsc.state.tx.us/news/meetings.asp](http://www.hhsc.state.tx.us/news/meetings.asp) for information related to a public rate hearing for these reimbursement rates, which will be held at a future date. ■

## Prior Authorization Requirements for Removable Prosthodontics for Cleft Palate Clients Have Changed

Effective for dates of service or after October 1, 2011, providers are not required to submit diagnostic tools and radiographs with prior authorization requests for removable prosthodontics (procedure codes D5951, D5952, D5953, D5954, D5955, D5958, D5959, and D5960) for clients who have a cleft lip or cleft palate. The Texas Medicaid & Healthcare Partnership (TMHP) Medical Director may request additional information if it is necessary to make a determination.

Removable prosthodontics requires prior authorization and providers must complete a Texas HealthSteps (THSteps) Dental Mandatory Prior Authorization Request Form and narrative documentation of the medical need for the appliances.

If a prior authorization request for removable prosthodontics for a client who has a cleft lip or cleft palate was denied because diagnostic tools or radiographs were not included, the provider may resubmit the prior authorization request for approval. ■

### Orthodontic Prior Authorization Requirements When the Client Changes Providers

Effective for dates of service on or after January 1, 2012, providers who request prior authorization to complete orthodontic services that were started by another provider may submit photographs of the upper and lower arches instead of diagnostic models. ■

## Implementation of Benefit Changes for THSteps Orthodontic Dental Services Postponed

This is an update to an article titled “Benefit Changes for Texas Health Steps Orthodontic Dental Services Effective January 1, 2012,” which was published on the TMHP website at [www.tmhp.com](http://www.tmhp.com) on November 14, 2011. The implementation of these benefit changes was postponed, and current benefits will remain in effect after December 31, 2011. Providers should monitor future notifications for the new implementation date.

As previously announced, prior authorizations for most orthodontic services were suspended from January 1, 2012, to February 29, 2012.

During this time period, only the following exceptions will be processed through TMHP:

- Emergent conditions
- Intermediate care facilities for persons with intellectual disabilities (ICF-MR)
- Client’s who have one of the following special medical conditions:
  - Cleft palate
  - Head-trauma injury involving the oral cavity
  - Skeletal anomalies involving the oral cavity
- Client’s who have already been approved and started treatment

Beginning March 1, 2012, prior authorization requests for orthodontic services for Medicaid clients who have transitioned to Medicaid managed care will be submitted to the client’s dental plan instead of TMHP.

If a client has been receiving orthodontic services with a date of service on or before February 29, 2012, and needs additional services between January 1, 2012, through February 29, 2012, the provider may continue to submit claims to TMHP for these services, and TMHP will continue to reimburse and process these claims. TMHP will be responsible for processing and reimbursing orthodontic claims with a date of service prior to March 1, 2012, only if the services were already prior authorized by TMHP.

Effective for dates of service on or after March 1, 2012, the dental plans will be responsible for prior authorizing, processing, and reimbursing any orthodontic services rendered to Medicaid clients. This includes processing and reimbursing claims for orthodontic services that were initially prior authorized by TMHP but subsequently transitioned to the dental plan.

Effective for dates of service on or after March 1, 2012, TMHP will continue to prior authorize, process, and reimburse orthodontic services rendered to Medicaid fee-for-service clients with the following conditions:

- Clients who have an emergent condition (trauma, pain)
- Intermediate care facilities for persons with intellectual disabilities (ICF-MR)
- Clients who have one of the following special medical conditions:
  - Cleft palate
  - Head-trauma injury involving the oral cavity
  - Skeletal anomalies involving the oral cavity



## EXCLUDED PROVIDERS

## Excluded Providers

As required by the Medicare and Medicaid Patient Protection Act of 1987, the Health and Human Services Commission (HHSC) identifies providers or employees of providers who have been excluded from state and federal health-care programs. Providers excluded from Texas Medicaid and Title XX Programs must not order or prescribe services to clients after the exclusion date. Services rendered under the medical direction or under the prescribing orders of an excluded provider also will be denied. Providers who submit cost reports cannot include the salaries, wages, or benefits of employees who have been excluded from Medicaid. Also, excluded employees are not permitted to provide Medicaid services to any client.

Medicaid providers are responsible for checking the exclusion list on all employees upon hiring and periodically thereafter. Providers are liable for all fees paid to them by Texas Medicaid for services rendered by excluded individuals. Providers are subject to a retrospective audit and recoupment of any Medicaid funds paid for services. It is strongly recommended that providers conduct frequent periodic checks of the HHSC exclusion list. The HHSC-Sanctions Department submits updates to the exclusion list periodically and the updates appear on the website weekly.

Review the entire Texas Medicaid exclusion list at <https://oig.hhsc.state.tx.us/Exclusions/Search.aspx>.

To report Medicaid providers who engage in fraud/abuse, call (512) 424-6519 or 1-800-436-6184, or write to the following address:

Brian Klozik, Director  
 HHSC Office of Inspector General, Medicaid Provider Integrity, MC-1361  
 PO Box 85200  
 Austin, TX 78708-5200

Provider	License Number	Add Date	Type Provider	City	State	Effective Date
Abernathy, Michael A.	170257	14-Dec-11	LVN	Sherman	TX	9-Aug-11
Acosta, Louise A.	118753	15-Nov-11	LVN	Marlin	TX	10-May-11
Adegbuyi, Biola A.		30-Dec-11	DME Owner	Richardson	TX	20-Dec-10
Adeshola, Elizabeth O.	225484	1-Nov-11	LVN	Arlington	TX	16-May-11
Ahi, Tony O.		5-Dec-11	Office Manager	Houston	TX	30-Sep-11
Akemon, Jeniva A.	122456	22-Dec-11	LVN	Wellington	TX	10-May-11
Aldridge, Marjorie L.	121120	1-Nov-11	LVN	Fort Worth	TX	14-Dec-10
Allen, Jessica K.		5-Dec-11	Med. Assistant	Brookfield	WI	30-Sep-11
Allen, Julia A.	222035	1-Nov-11	RN	Tyler	TX	14-Dec-10
Allred, Melody	141929	15-Nov-11	LVN	Channelview	TX	14-Jun-11
Alvarado, Gloria J.	85518	14-Dec-11	LVN	San Antonio	TX	9-Aug-11
Alvarez, Heron B.		5-Jan-12	Supervisor	Roma	TX	30-Mar-11
Anders, Kristy D.	658665	29-Nov-11	RN	San Angelo	TX	26-Apr-11
Anderson, Deborah H.	196613	1-Nov-11	LVN	Haltom City	TX	14-Dec-10
Anthony Coleman, La K.	194490	29-Nov-11	LVN	Lakewood	WA	14-Jun-11
Anunobi, Marcelleus J.	37743	2-Nov-11	Pharm./Owner	Beeville	TX	20-Jul-11

Provider	License Number	Add Date	Type Provider	City	State	Effective Date
Arnold, Weston L.	157168	10-Nov-11	LVN	San Antonio	TX	10-May-11
Ballard, Josephine S.	22908	15-Dec-11	LVN	Rosenberg	TX	10-May-11
Barnes, Russell G.	581438	6-Dec-11	RN	Boerne	TX	10-May-11
Bassford, Dorval	632785	6-Dec-11	RN	Fort Worth	TX	10-May-11
Benavides, Abram	226121	1-Nov-11	LVN	Alice	TX	14-Jun-11
Benson, Timothy T.	149964	29-Nov-11	LVN	Tyler	TX	14-Jun-11
Berlanga, Jose	615075	30-Dec-11	RN	Bakersfield	CA	31-May-11
Beveridge, Wiley J.	65377	29-Nov-11	LVN	Nacogdoches	TX	27-Apr-11
Bradford, Michael J.	698628	10-Nov-11	RN	Houston	TX	10-May-11
Brash, Trent C.	579323	21-Dec-11	RN	Patterson Heights	PA	21-Jul-11
Breckenridge, Stephanie A.	157891	30-Nov-11	LVN	Montgomery	TX	10-May-11
Brodeth, Alison B.	778918	30-Dec-11	RN	Longview	TX	14-Jun-11
Brown, Marlene L.	759428	1-Nov-11	RN	Frisco	TX	14-Jun-11
Brown, Martha E.	119261	1-Nov-11	LVN	Corsicana	TX	4-Jun-11
Brown, Robert	625502	15-Nov-11	RN	Minden	LA	10-May-11
Burkeen, Nathan L.	136575	21-Dec-11	LVN	Greenville	MS	9-Aug-11
Burt, Leighann E.	107978	22-Nov-11	LVN	George West	TX	14-Jun-11
Caffey, Jennifer J.	163846	5-Dec-11	LVN	Lubbock	TX	10-May-11
Cain, Angela C.	677730	15-Nov-11	RN	Keller	TX	14-Jun-11
Campbell, Carolyn V.	176977	15-Nov-11	LVN	Brenham	TX	3-Jun-11
Cassidy, Alicia H.		5-Dec-11	DME Acc. Rep.	Grapevine	TX	31-Mar-11
Clodfelter, Traci L.	751771	16-Nov-11	RN	Grove	OK	27-May-11
Cobhan, Essien C.		10-Nov-11	Owner of DME	Cedar Hill	TX	30-Aug-11
Cook, James T.	none	1-Nov-11	Owner/Admin	Gilmer	TX	17-Oct-11
Craven, Esther S.	433699	9-Nov-11	RN	Arlington	TX	10-May-11
Cress, Susanna E.	461848	1-Nov-11	RN	Rock Springs	WY	13-May-11
Cummings, Linda D.	201864	16-Nov-11	LVN	White House	TX	14-Jun-11
Davenport, Jeremy C.		5-Dec-11	RN/LVN	Woodsboro	TX	10-May-11
Davies, Eliza S.	772278	5-Dec-11	RN	Sherman	TX	14-Jun-11
Davis, Leigh A.		22-Dec-11	Owner	Carthage	TX	7-Jun-11
Decas, Patricia L.	185295	16-Nov-11	LVN	Seguin	TX	14-Jun-11
Delavan, Bonnie K.	234834	4-Nov-11	RN	Laguna Niguel	CA	10-May-11
Delgado, Carlos	133172	15-Nov-11	LVN	Denver	CO	10-May-11
Delgado, Sylvia C.	N.A.	2-Nov-11	Billing Clerk	Bryan	TX	20-Jul-11
Disque, Theodore	684611	22-Nov-11	RN	McAllen	TX	14-Jun-11
Dobbs, Janet L.	747512	29-Nov-11	RN	Vian	OK	14-Jun-11
Duke, Deborah L.	240665	9-Nov-11	RN	Cypress	TX	10-May-11
Durojaiye, Abiodun O.		13-Dec-11	Owner	Beaumont	TX	20-Jul-11
Dyer, Peggy J.	56977	10-Nov-11	LVN	Granbury	TX	10-May-11
Dymond, Elza	94075	28-Nov-11	LVN	San Antonio	TX	14-Jun-11

Provider	License Number	Add Date	Type Provider	City	State	Effective Date
Ellis , Mary L.	112176	1-Dec-11	LVN	Missouri City	TX	23-Jun-11
Etinfoh, Helen E.		5-Dec-11	DME Owner	Bryan	TX	30-Sep-11
Faust, Tina F.	90068	29-Nov-11	LVN	Spring	TX	14-Jun-11
Feuge , Glenda G.	7778	8-Dec-11	CMA	Fredericksburg	TX	19-Jan-11
Finch, Albert B.	C3297	4-Jan-12	MD	Odessa	TX	26-Aug-11
Fintan, Marshall I.	690642	1-Nov-11	RN	Rosenberg	TX	28-Apr-11
Fomby, Elizabeth A.	119373	30-Dec-11	LVN	Texarkana	TX	14-Jun-11
Fountain, Dovie C.	116278	30-Dec-11	LVN	Katy	TX	14-Jun-11
Franklin, Keith A.	141504	15-Dec-11	LVN	Waco	TX	10-May-11
Freeman, Brenda S.	145073	14-Dec-11	LVN	Greenville	TX	15-Jul-11
Frugia , Christy N.	640928	1-Dec-11	RN	Beaumont	TX	15-Jun-11
Galindo, Carmen M.	186707	29-Nov-11	LVN	San Antonio	TX	10-May-11
Gentry, Amy L.	659429	14-Dec-11	RN	Soper	OK	5-Jul-11
Germany, Virginia L.	105331	9-Nov-11	LVN	Tomball	TX	10-May-11
Gonzalez, Oscar J.	150270	15-Dec-11	LVN	San Antonio	TX	14-Jun-11
Goodwin, Kelly R.	172899	22-Dec-11	LVN	Como	TX	10-May-11
Gordan, Shelia R.	180646	10-Nov-11	LVN	Temple	TX	10-May-11
Green, Mitzi C.	62809	16-Nov-11	LVN	Monahans	TX	14-Jun-11
Green, Sharon R.	105786	1-Nov-11	LVN	Kilgore	TX	27-Jan-11
Hale, Marie E.	243892	7-Dec-11	RN	Dallas	TX	14-Jun-11
Hamilton , Irine B.	76988	20-Dec-11	LVN	Munday	TX	9-Aug-11
Hamilton, Carol A.	535762	1-Nov-11	RN	Tyler	TX	13-Oct-10
Hardebeck, Edward J.	511050	4-Nov-11	RN	Shreveport	LA	10-May-11
Hart, Robin A.	182477	30-Dec-11	LVN	Hot Springs	AR	27-Apr-11
Hartley, Harriet M.	572506	14-Dec-11	RN	New Braunfels	TX	21-Jul-11
Hatton, Brenda J.	537378	5-Dec-11	RN	Wallis	TX	1-Dec-10
Hatzer, Sean S.	206129	15-Nov-11	LVN	North Lewisburg	OH	9-Jun-11
Hill, Tina L.	135410	2-Dec-11	LVN	Anna	TX	10-May-11
Hinkle, Mark A.	595138	8-Dec-11	RN	Westpoint	TX	14-Jun-11
Holcombe, Eric L.	134649	15-Nov-11	LVN	Groveton	TX	7-Jun-11
Holder, Rosemarie J.	438128	15-Nov-11	RN	Cleburne	TX	10-May-11
Hollis, Vanessa D.	163302	2-Dec-11	LVN	Colorado City	TX	10-May-11
Hopper, Tracey L.	132993	10-Nov-11	LVN	Oklahoma City	OK	10-May-11
Houts , Anita M.	428204	1-Dec-11	RN	Mineola	TX	18-May-11
Hytchye, Vicki J.	111434	28-Nov-11	LVN	San Antonio	TX	14-Jun-11
James, Edward Y.	171844	1-Nov-11	LVN	Abilene	TX	27-May-11
Johnson, Angela M.	647975	21-Nov-11	RN	Frisco	TX	20-Jul-11
Johnson, Elizabeth K.	135372	4-Jan-12	LVN	White Oak	TX	21-Jul-11
Johnson, Kerste J.	G7072	13-Dec-11	Physician	Athens	TX	15-Feb-11
Johnson, Virginia L.	108680	2-Dec-11	LVN	Haynesville	LA	5-Oct-11

Provider	License Number	Add Date	Type Provider	City	State	Effective Date
Jones, Alvin E.	107098	28-Nov-11	LVN	Seguin	TX	10-May-11
Jones, Genene A.	74282	28-Nov-11	LVN	Dickinson	TX	10-Jun-11
Joslin, Gordon L.	640879	17-Nov-11	RN	Waco	TX	28-Apr-11
Kaluanya, Mento N.		2-Nov-11	Owner	Three Rivers	TX	20-Jul-11
Kendabie, Linda E.		5-Dec-11	Office Assistant	Sugarland	TX	29-Nov-10
Kidd, Lori J.	187084	22-Dec-11	LVN	Sweetwater	TX	9-Aug-11
King, Tracy D.	126204	8-Dec-11	LVN	Salina	KS	10-May-11
Kitchen, Venus S.	116283	15-Nov-11	LVN	Crockett	TX	10-May-11
Kraft, Walter G.	784878	4-Jan-12	RN	New Era	MI	13-Jul-11
Krupka, Cyril R.		5-Dec-11	Owner	Lewisville	TX	31-Mar-11
Lachman, John R.		5-Dec-11	Office Manager	Houston	TX	28-Apr-10
Lawson Brown, Tracy A.	678897	4-Jan-12	RN	Iowa Park	TX	2-Aug-11
Leal , Eloy R.		30-Nov-11		San Benito	TX	22-Nov-11
LeBlanc, Rene M.	724702	30-Dec-11	RN	Metairie	LA	8-Feb-11
LeClair , Heidi L.	112866	1-Dec-11	Pharm. Tech	Trinity	TX	18-Aug-11
Leddy, Vickie L.	97916	2-Dec-11	LVN	Wimberly	TX	14-Jun-11
Lee, Clinton		5-Dec-11	Employee	Houston	TX	2-Jun-10
Lee, Marilyn E.	632927	1-Nov-11	RN	Manvel	TX	28-Apr-11
Lee, Thomas	11247	1-Nov-11	DDS	San Augustine	TX	23-Mar-01
Love, Herbert H.	192852	9-Nov-11	LVN	Abilene	TX	29-Apr-11
Maciel, Teresa L.	125614	28-Nov-11	LVN	San Angelo	TX	14-Jun-11
Mackie, David R.	156056	1-Dec-11	LVN	Willis	TX	10-May-11
Maddock, Penelope A.	235430	22-Dec-11	RN	Plano	TX	14-Jul-11
Magana, Omar J.	736148	3-Nov-11	RN	El Paso	TX	10-May-11
Mantegna-Vandiver, Lori A.	171486	9-Dec-11	LVN	Arlington	TX	14-Jun-11
Martin, Robert R.	643249	9-Nov-11	RN	Austin	TX	27-Apr-11
Mathis, Ethel L.	774898	15-Nov-11	RN	Utica	NY	8-Jun-11
Matthews, Rebecca J.	48480	15-Dec-11	LVN	Lubbock	TX	10-May-11
McBride, Rosemary J.	442665	22-Dec-11	RN	Colorado Springs	CO	18-Jul-11
McCarthy, Janice G.	698813	1-Nov-11	RN	Pampa	TX	23-May-11
McCurry, Karen A.	115826	20-Dec-11	LVN	Kirbyville	TX	10-May-11
McGill, Jacqueline D.	697028	1-Dec-11	RN	Oakland	CA	23-Jun-11
McJunkin, Tammy L.	688632	1-Nov-11	RN	Big Springs	TX	14-Jun-11
McSherry, Gordon E.	668440	15-Nov-11	RN	Issaquah	WA	10-May-11
Mercer, Ann M.	55576	14-Dec-11	LVN	Amarillo	TX	20-Sep-11
Miles, Glenda G.	140365	2-Dec-11	LVN	Abilene	TX	10-May-11
Miller, Mary H.	244565	15-Nov-11	RN	Fredericksburg	TX	13-Jun-11
Miller-Klecka, Ann M.	601607	28-Nov-11	RN	Whitney	TX	10-May-11
Montgomery, Latonya H.	685358	15-Nov-11	RN	Plano	TX	10-May-11
Montgomery, Whitney B.	192465	9-Nov-11	LVN	Robert Lee	TX	29-Apr-11

Provider	License Number	Add Date	Type Provider	City	State	Effective Date
Moore, Amy M.	166454	20-Dec-11	LVN	Cleburne	TX	10-May-11
Moore, Angela R.	137983	15-Dec-11	LVN	East Wenatchee	WA	10-May-11
Moore, Carol S.	228097	22-Nov-11	RN	Bastrop	TX	14-Jun-11
Morgan, Wendy G.	201913	14-Dec-11	LVN	Sidell	LA	9-Aug-11
Morris, Linda	590600	14-Dec-11	RN	Lancaster	TX	29-Jun-11
Moss, Holly I.	519253	5-Jan-12	RN	Cincinnati	OH	18-Jul-11
Muirhead, Tamara L.	136922	9-Dec-11	LVN	Splendora	TX	10-May-11
Nichols, Deidra H.	548125	22-Nov-11	RN	Santa Fe	TX	14-Jun-11
Njoku, Caroline	188446	1-Dec-11	LVN	Houston	TX	8-Jun-11
Njoku, Princewill J.	568273	1-Dec-11	RN	Houston	TX	8-Jun-11
Nkuku, Oliver N.		30-Dec-11	DME Owner	Anthony	TX	29-Nov-10
Ogunlana, Monsurat A.	583831	1-Dec-11	RN	Sugar Land	TX	23-Jun-11
Onyegbu, Florence	184477	1-Dec-11	LVN	Flower Mound	TX	18-Aug-11
Ott, Deborah L.	733942	28-Nov-11	RN	Houston	TX	10-May-11
Patterson, Sabrina R.	178226	9-Nov-11	LVN	Wichita Falls	TX	12-May-11
Paul, Donna L.	105850	2-Dec-11	LVN	Scurry	TX	10-May-11
Pederson, Ellen P.	121762	8-Nov-11	LVN	Victoria	TX	10-May-11
Pee, Jaime N.	208768	9-Nov-11	LVN	Gladewater	TX	10-May-11
Pena, Theresa A.	85188	9-Nov-11	LVN	Austin	TX	10-May-11
Peterson, Sarah A.	714232	1-Dec-11	RN	Abilene	TX	27-Jun-11
Pogue, Kelly A.	697860	9-Nov-11	RN	Garland	TX	27-Apr-11
Popoff, Reesa N.	629048	3-Nov-11	RN	Plains	MT	20-Jul-11
Posey, Kathi L.	80663	1-Nov-11	LVN	La Vernia	TX	14-Jun-11
Price, Michelle D.	151737	2-Dec-11	LVN	Plainview	TX	10-May-11
Raines, Phillip	628161	22-Dec-11	RN	Deville	LA	15-Jul-11
Ramirez, Thelma	125488	28-Nov-11	LVN	Fort Stockton	TX	14-Jun-11
Ramos, Rhonda M.	134817	9-Nov-11	LVN	Boling	TX	28-Apr-11
Randolph, Mercedes G.		1-Nov-11		Meadow	TX	30-Oct-11
Raspaldo, Michelle R.	161829	21-Nov-11	LVN	Gatesville	TX	10-May-11
Read, Claudette T.		2-Dec-11	Bus. Owner	Kountze	TX	22-Nov-11
Read, Robert E.		2-Dec-11	Bus. Owner	Kountze	TX	22-Nov-11
Reece, William M.		1-Dec-11	Owner	Butner	NC	18-Aug-11
Reed, Christina N.	206513	28-Nov-11	LVN	Deweyville	TX	14-Jun-11
Reed, Kevin W.	773221/ 161070	15-Dec-11	RN/LVN	Corpus Christi	TX	10-May-11
Rettersdorf, Julie	610938	30-Dec-11	RN	Austin	TX	27-Apr-11
Reyes, Saul	199855	1-Nov-11	LVN	Weslaco	TX	26-May-11
Reynolds, Tracie H.	189134	3-Nov-11	LVN	Whitehouse	TX	23-Oct-11
Rider, Patricia C.	90378	14-Dec-11	LVN	Weatherford	TX	21-Jul-11
Roland, Karla	694568	10-Nov-11	RN	San Jose	CA	14-Jun-11
Sandifer, Byron W.	631640	9-Nov-11	RN	Longview	TX	28-Apr-11

Provider	License Number	Add Date	Type Provider	City	State	Effective Date
Sears, Sarah E.	212561	9-Nov-11	LVN	New Braunfels	TX	10-May-11
Shaw, Desiree A.	88699	5-Jan-12	LVN	Gatesville	TX	9-Aug-11
Shegda, David	752203	22-Dec-11	RN	Waxahachie	TX	5-Jul-11
Sherman, Stephen H.	G-2022	9-Nov-11	MD	Arcadia	CA	8-Apr-11
Smith , Patricia A.	119723	1-Dec-11	LVN	Perryton	TX	23-Jun-11
Smith, Lisa J.	165152	1-Nov-11	LVN	Elk City	OK	24-May-11
Smith, Marcia L.	LPC 10092	14-Dec-11	Counselor	Houston	TX	20-Sep-05
Somoso, Paul A.	732493	9-Nov-11	RN	Mission	TX	26-Apr-11
Soto, Hernando D.	179797	9-Nov-11	LVN	Lubbock	TX	7-Apr-11
Starnes , Kerri D.	150151	1-Dec-11	LVN	Bridgeport	TX	14-Jun-11
Steele, Holly C.	155463	9-Nov-11	LVN	Orange	TX	8-Mar-11
Steffen, Becky L.	586125	10-Nov-11	RN	Pleasanton	TX	10-May-11
Stewart , Toni D.	75086	1-Dec-11	LVN	Eules	TX	17-Jun-11
Stretch, Myrna L.	724082	22-Dec-11	RN	Muskogee	OK	1-Jul-11
Suggs, Rae L.	62255	22-Nov-11	LVN	Greenville	TX	27-May-11
Swann, Amanda Y.	744837	4-Nov-11	RN	New Boston	TX	14-Jun-11
Swartz, Denise	110290	2-Dec-11	LVN	Spring	TX	10-May-11
Symes, Robert M.	461309	5-Jan-12	RN	Wichita	TX	9-Aug-11
Tear, Robert W.	252176	4-Jan-12	RN	Dallas	TX	9-Aug-11
Thomas, Aleyamma G.	461935	9-Nov-11	RN	Everett	WA	25-Apr-11
Thomas, Sandra A.	617757	22-Nov-11	RN	Monroe	MI	14-Jun-11
Thomas, Syretha A.	527321	28-Nov-11	RN	Post	TX	14-Jun-11
Thompson, Brian D.	205311	9-Nov-11	LVN	Heartland	TX	10-May-11
Tidwell, Hubert M.	120721	14-Dec-11	LVN	El Paso	TX	9-Aug-11
Tinsley, Angela M.	175388	28-Nov-11	LVN	Colmesneil	TX	14-Jun-11
Trevino, Carlos	134322	22-Nov-11	LVN	La Feria	TX	10-May-11
Turner, John M.	No	15-Dec-11	Fiduciary/RN	Beeville	TX	17-May-11
Upchurch , Michael L.	242869	1-Dec-11	RN	The Colony	TX	14-Jun-11
Upshaw, Sharon K.	173322	16-Nov-11	LVN	Waxahachie	TX	14-Jun-11
Vinitiski, Doris N.	N/A	4-Nov-11	Owner	Houston	TX	23-Oct-11
Vynanek, John R.	557517	29-Nov-11	RN	Jacksonville	FL	23-May-11
Waible, Sandra S.	131346	9-Nov-11	LVN	Puyallup	WA	10-May-11
Wallace, Janet C.	244064	8-Nov-11	RN	Dallas	TX	13-Jun-11
Watkins, Loretta K.	248399	22-Nov-11	RN	Ravenna	TX	10-May-11
Watkins, Sharon K.	N.A.	3-Nov-11	Individual	Mount Vernon	TX	23-Oct-11
Watson, Jacqueline M.	138563	4-Jan-12	LVN	Dallas	TX	9-Aug-11
Wenzel, Danna L.	672168	10-Nov-11	RN	San Antonio	TX	10-May-11
Wheat, Heather L.	564856	1-Dec-11	RN	Beaumont	TX	10-May-11
Wheeler, Sharon K.	574139	15-Nov-11	RN	Pasadena	TX	10-May-11
White, Laura C.	636974	1-Nov-11	RN	Whitehouse	TX	20-May-11
Wiggins, Michael D.	183537	9-Dec-11	LVN	Pensacola	FL	10-May-11

Provider	License Number	Add Date	Type Provider	City	State	Effective Date
Williams, Leslie C.	120569	14-Dec-11	LVN	Lubbock	TX	9-Aug-11
Williams, Sandra J.	149922	16-Nov-11	LVN	Monahans	TX	14-Jun-11
Williams, Stacy P.	13010	1-Dec-11	Dental Assistant	Sulphur Springs	TX	5-Aug-11
Willis, Angela H.		21-Nov-11	Employee	Richmond	TX	7-Nov-11
Wilson, Carolyn G.	512252	1-Dec-11	RN	Splendora	TX	14-Jun-11
Wood, Gerrold G.	76906	10-Nov-11	LVN	Bexar	AR	10-May-11
Wood, Markeshe	223075	15-Dec-11	LVN	Jackson	TN	14-Jun-11
Wright, Kevin J.	765305	30-Dec-11	RN	Port Richey	FL	14-Jun-11
Wright, Vanessa C.	213765	9-Dec-11	LVN	Monahans	TX	14-Jun-11
Wynn , Deborah	643455	1-Dec-11	RN	Lake Dallas	TX	17-Jun-11
Zavala, Paul	169393	2-Nov-11	LVN	Corpus Christi	TX	20-Jul-11
Zecha, Laura L.	673893	5-Jan-12	RN	Phoenix	AZ	9-Aug-11
Zrodowski, John E.	708979	1-Dec-11	RN	San Diego	CA	23-Jun-11
Zuniga, Andres	649674	29-Nov-11	RN	Saint Louis	MO	10-May-11

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## Electronic Funds Transfer (EFT) Notification

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Electronic Funds Transfer (EFT) is a payment method used to deposit funds directly into a provider's bank account. These funds can be credited to either checking or savings accounts, if the provider's bank accepts Automated Clearinghouse (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks by ensuring funds are directly deposited into a specified account.

The following items are specific to EFT:

- Pre-notification to your bank occurs on the weekly cycle following the completion of enrollment in EFT.
- Future deposits are received electronically after pre-notification.
- The Remittance and Status (R&S) report furnishes the details of individual credits made to the provider's account during the weekly cycle.
- Specific deposits and associated R&S reports are cross-referenced by both the provider identifiers (i.e., NPI, TPI, API) and R&S number.
- EFT funds are released by TMHP to depository financial institutions each Thursday.
- The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and time frame as currently received.

TMHP must provide the following notification according to ACH guidelines:

Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. Contact your financial institution regarding posting time if funds are not available on the release date.

However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution, who in turn should work out the best way to serve their customer's needs.

In all cases, credits received should be posted to the customer's account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date.

To enroll in the EFT program, complete the attached Electronic Funds Transfer Authorization Agreement. **You must return a voided check or signed letter from your bank on bank letterhead with the agreement to the TMHP address indicated on the form.**

Call the **TMHP Contact Center** at **1-800-925-9126** if you need assistance.



## Electronic Funds Transfer (EFT) Notification

**NOTE:** Complete all sections below and attach a voided check or a signed letter from your bank on bank letterhead.

Type of authorization: <input type="checkbox"/> New <input type="checkbox"/> Change				
Provider name:			Billing TPI: (9-digit)	
National Provider Identifier (NPI)/Atypical Provider Identifier (API):			Primary taxonomy code:	
List any additional TPIs that use the same provider information:				
TPI:	TPI:	TPI:	TPI:	
TPI:	TPI:	TPI:	TPI:	
Provider accounting address:				
Number	Street	Suite	City	State    ZIP
Provider phone number:				
Bank name:			Bank phone number:	
ABA/Transit number:			Account number:	
Bank address:			Account type: (check one)	
			<input type="checkbox"/> Checking <input type="checkbox"/> Savings	

I (we) hereby authorize Texas Medicaid & Healthcare Partnership (TMHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Health and Human Services Commission (HHSC) or its contractor. I (we) understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

Authorized signature:		Date:	
Title:		E-mail address: (if applicable)	
Contact name:		Contact phone number:	

**Return this form to:**  
Texas Medicaid & Healthcare Partnership  
ATTN: Provider Enrollment  
PO Box 200795  
Austin, TX 78720-0795

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EFT Authorization

## Provider Information Change Form

Texas Medicaid fee-for-service, Children with Special Health Care Needs (CSHCN) Services Program, and Primary Care Case Management (PCCM) providers can complete and submit this form to update their provider enrollment file. Print or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address at the bottom of the page.				
Check the box to indicate a PCCM Provider <input type="checkbox"/>			Date :     /     /	
Nine-Digit Texas Provider Identifier (TPI):		Provider Name:		
National Provider Identifier (NPI):		Primary Taxonomy Code:		
Atypical Provider Identifier (API):		Benefit Code:		
List any additional TPIs that use the same provider information:				
TPI:	TPI:	TPI:		
TPI:	TPI:	TPI:		
TPI:	TPI:	TPI:		
<b>Physical Address</b> —The physical address cannot be a PO Box. Ambulatory Surgical Centers enrolled with Traditional Medicaid who change their ZIP Code must submit a copy of the Medicare letter along with this form.				
Street address	City	County	State	Zip Code
Telephone: (     )     (     )     (     )	Fax Number: (     )     (     )     (     )	Email:		
<b>Accounting/Mailing Address</b> —All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.				
Street Address	City	State	Zip Code	
Telephone: (     )     (     )     (     )	Fax Number: (     )     (     )     (     )	Email:		
<b>Secondary Address</b>				
Street Address	City	State	Zip Code	
Telephone: (     )     (     )     (     )	Fax Number: (     )     (     )     (     )	Email:		
<b>Type of Change (check the appropriate box)</b>				
<input type="checkbox"/>	Change of physical address, telephone, and/or fax number			
<input type="checkbox"/>	Change of billing/mailling address, telephone, and/or fax number			
<input type="checkbox"/>	Change/add secondary address, telephone, and/or fax number			
<input type="checkbox"/>	Change of provider status (e.g., termination from plan, moved out of area, specialist) <i>Explain in the Comments field</i>			
<input type="checkbox"/>	Other (e.g., panel closing, capacity changes, and age acceptance)			
<b>Comments:</b>				
<b>Tax Information—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)</b>				
Tax ID number:		Effective Date:		
Exact name reported to the IRS for this Tax ID:				
<b>Provider Demographic Information—Note: This information can be updated on <a href="http://www.tmhp.com">www.tmhp.com</a>.</b>				
Languages spoken other than English:				
Provider office hours by location:				
Accepting new clients by program (check one): Accepting new clients <input type="checkbox"/> Current clients only <input type="checkbox"/> No <input type="checkbox"/>				
Patient age range accepted by provider:				
Additional services offered (check one): HIV <input type="checkbox"/> High Risk OB <input type="checkbox"/> Hearing Services for Children <input type="checkbox"/>				
Participation in the Woman's Health Program? Yes <input type="checkbox"/> No <input type="checkbox"/>			Patient gender limitations: Female <input type="checkbox"/> Male <input type="checkbox"/> Both <input type="checkbox"/>	
<b>Signature and date are required or the form will not be processed.</b>				
Provider signature:			Date:     /     /	
<b>Mail or fax the completed form to:</b>				
Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment PO Box 200795 Austin, TX 78720-0795			Fax: 512-514-4214	

Effective Date\_09012009/Revised Date\_08212009

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## Instructions for Completing the Provider Information Change Form

### Signatures

- The provider's signature is required on the Provider Information Change Form for any and all changes requested for individual provider numbers.
- A signature by the authorized representative of a group or facility is acceptable for requested changes to group or facility provider numbers.

### Address

- Performing providers (physicians performing services within a group) may *not* change accounting information.
- For Texas Medicaid fee-for-service and the CSHCN Services Program, changes to the accounting or mailing address require a copy of the W-9 form.
- For Texas Medicaid fee-for-service, a change in ZIP Code requires copy of the Medicare letter for Ambulatory Surgical Centers.

### Tax Identification Number (TIN)

- TIN changes for individual practitioner provider numbers can only be made by the individual to whom the number is assigned.
- Performing providers *cannot* change the TIN.

### Provider Demographic Information

An online provider lookup (OPL) is available, which allows users such as Medicaid clients and providers to view information about Medicaid-enrolled providers. To maintain the accuracy of your demographic information, please visit the OPL at [www.tmhp.com](http://www.tmhp.com). Please review the existing information and add or modify any specific practice limitations accordingly. This will allow clients more detailed information about your practice.

### General

- TMHP must have either the nine-digit Texas Provider Identifier (TPI), or the National Provider Identifier (NPI)/Atypical Provider Identifier (API), primary taxonomy code, physical address, and benefit code (if applicable) in order to process the change. Forms will be returned if this information is not indicated on the Provider Information Change Form.
- The W-9 form is required for *all* name and TIN changes.
- Mail or fax the completed form to:  
Texas Medicaid & Healthcare Partnership (TMHP)  
Provider Enrollment  
PO Box 200795  
Austin, TX 78720-0795  
Fax: 512-514-4214

## Principal Information Form (PIF-2)

**Required for any person or entity not seeking a Provider Identifier but meets the definition of a "Principal" or "Subcontractor" as defined below.**

A separate copy of this Principal Information Form (PIF-2) must be completed in full for each Principal or Subcontractor of the Provider, before enrollment.

A **Principal** of the Provider is defined as follows:

- All owners with a direct or indirect ownership or control interest of 5 percent or more.
- All corporate officers and directors, all limited and non-limited partners, and all shareholders of a provider entity (including a professional corporation, professional association, or limited liability company).
- All managing employees or agents who exercise operational or managerial control, or who directly or indirectly manage the conduct of day-to-day operations

A **Subcontractor** of the Provider is defined as follows:

- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies

All spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Principal or Subcontractor.

The Provider or provider's duly authorized representative must personally review each copy of this completed form and certify to the validity and completeness of the information provided by signing the HHSC Medicaid Provider Agreement.

<b>Check principal or subcontractor:</b>		<input type="checkbox"/> Principal	<input type="checkbox"/> Subcontractor
<b>Name – Last, First, Middle Initial:</b>		<b>Maiden name:</b>	
<b>List any other alias, name, or form of your name ever used:</b>			

*For additional names or addresses, attach pages as necessary.*

<b>Physical address:</b>					
Number	Street	Suite	City	State	ZIP
<b>Accounting/billing address:</b>					
Number	Street	Suite	City	State	ZIP
<b>If your accounting address is different than your physical address, indicate your relationship to the accounting address:</b>					
<input type="checkbox"/> Billing agent	<input type="checkbox"/> Management company	<input type="checkbox"/> Employer	<input type="checkbox"/> Self	<input type="checkbox"/> Other ( <i>explain below</i> )	
<i>If you chose Other, please explain:</i>					

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<b>Professional Licensing or Certification Board, Professional License Number and State:</b> <i>(if applicable)</i>		<b>Initial issue date:</b> MM/DD/YYYY	<b>Expiration date:</b> MM/DD/YYYY	
<b>Pharmacist Immunization Certification or CCNA Certification:</b>		<b>Issue date:</b> MM/DD/YYYY	<b>Expiration date:</b> MM/DD/YYYY	
<b>Social Security Number:</b>		<b>Federal Tax ID number:</b>		
<b>Specialty of practice:</b> <i>(i.e., pediatrics, general practice, etc.)</i>		<b>Medicare intermediary:</b> <i>(if applicable)</i>		
<b>Medicare provider number:</b> <i>(if applicable)</i>		<b>Medicare effective date:</b> MM/DD/YYYY <i>(if applicable)</i>		
<b>Driver's license number:</b>	<b>State:</b>	<b>Driver's license expiration date:</b> MM/DD/YYYY		
<b>Date of birth:</b> MM/DD/YYYY		<b>Gender:</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female
<b>Previous Physical address:</b>				
Number	Street	Suite	City	State ZIP
<b>Previous Accounting address:</b>				
Number	Street	Suite	City	State ZIP
<b>Your title in the provider organization for which enrollment is being sought:</b>				
<b>Your duties to the provider organization:</b> <i>(attach additional sheets if necessary)</i>				
<b>Your relationship to the provider organization. Relationship types include Accountant, Aunt/Uncle/Cousin, Acquaintance, Agency, Attorney, Banker, Bookkeeper, Business, Care Giver, Consultant, Contractual, Corporate Officer, Director, Doctor, Elected Official, Employee, Employer, Ex-Spouse/Ex-Domestic Partner, Friend, Grandparent, Government Official, In-Law/Ex-In-Law, Individual (Contracted), Individual (Fiscal Agent), Limited Partner, Managing Employee, Non-Limited Partner, Nurse, Official, Owner (Direct), Owner (Indirect) Parent, Recruiter, Representative, Shareholder, Sibling, Son/Daughter, Spouse/Domestic Partner, Subcontractor, or Unknown:</b> <i>(attach additional sheets if necessary)</i>				
<b>List all TPIs, provider names, and physical locations under which you have billed or in which you were a principal. Include current and previous TPIs :</b> <i>(attach additional sheets if necessary)</i>				

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List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. (attach additional sheets if necessary)

1.	<b>Name:</b>		<b>Social Security Number:</b>		<b>Date of birth: MM/DD/YYYY</b>		
	<b>Physical address:</b>						
	Number	Street	Suite	City	State	ZIP	
<b>Federal Tax ID:</b>		<b>TPI:</b>		<b>NPI/API:</b>			
2.	<b>Name:</b>		<b>Social Security Number:</b>		<b>Date of birth: MM/DD/YYYY</b>		
	<b>Physical address:</b>						
	Number	Street	Suite	City	State	ZIP	
<b>Federal Tax ID:</b>		<b>TPI:</b>		<b>NPI/API:</b>			
3.	<b>Name:</b>		<b>Social Security Number:</b>		<b>Date of birth: MM/DD/YYYY</b>		
	<b>Physical address:</b>						
	Number	Street	Suite	City	State	ZIP	
<b>Federal Tax ID:</b>		<b>TPI:</b>		<b>NPI/API:</b>			
4.	<b>Name:</b>		<b>Social Security Number:</b>		<b>Date of birth: MM/DD/YYYY</b>		
	<b>Physical address:</b>						
	Number	Street	Suite	City	State	ZIP	
<b>Federal Tax ID:</b>		<b>TPI:</b>		<b>NPI/API:</b>			
5.	<b>Name:</b>		<b>Social Security Number:</b>		<b>Date of birth: MM/DD/YYYY</b>		
	<b>Physical address:</b>						
	Number	Street	Suite	City	State	ZIP	
<b>Federal Tax ID:</b>		<b>TPI:</b>		<b>NPI/API:</b>			

<p><b>“Sanction” is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.</b></p> <p><b>Have you ever been sanctioned (as defined above) in any state or federal program?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><i>If Yes, fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (attach additional sheets if necessary)</i></p>	
<p><b>Is your professional license or certification currently revoked, suspended or otherwise restricted?</b></p> <p><b>Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?</b></p> <p><b>Are you currently, or have you ever been, subject to a licensing or certification board order?</b></p> <p><b>Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action?</b></p> <p><i>(You may be subject to a license or certification verification/status check with your licensing or certification board.)</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p><i>If Yes was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (attach additional sheets if necessary)</i></p>	
<p><b>“Convicted” means that:</b></p> <p><b>(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:</b></p> <p>    <b>(1) There is a post-trial motion or an appeal pending, or</b></p> <p>    <b>(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;</b></p> <p><b>(b) A Federal, State or local court has made a finding of guilt against an individual or entity;</b></p> <p><b>(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or</b></p> <p><b>(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.</b></p> <p><b>Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)?</b></p> <p><i>To answer this question, use the federal Medicaid/Medicare definition of “Convicted” in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><i>If Yes, fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)</i></p>	
<p><b>Are you currently behind 30 days or more on court ordered child support payments?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><i>If Yes, provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)</i></p>	
<p><b>Are you a citizen of the United States?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><i>If No, of what country are you a citizen?</i></p> <p><i>If you answered No above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.</i></p>	

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PIF-2

## Community and Migrant Health Center Affiliation Checklist

**Organization:** \_\_\_\_\_ **FQHC Site / NPI:** \_\_\_\_\_  
*(where applicable)*

### Type of Arrangement

- |   |  |
|---|--|
| <input type="checkbox"/> Merger<br><input type="checkbox"/> Acquisition<br><input type="checkbox"/> Parent Subsidiary Model<br><input type="checkbox"/> Establishment of a New Entity (e.g., Network Corporation)<br><input type="checkbox"/> Jointly Owned or Directed Jointly by a Health Center and an Affiliation Partner | <input type="checkbox"/> Contract for a portion of the project<br><input type="checkbox"/> Other (describe): _____<br><input type="checkbox"/> Not applicable<br>Name and Type of proposed Affiliate Organization(s):<br>_____<br>_____<br>_____ |
|---|--|

### Governance

Check "Yes" if in compliance, or "No" if not. Identify reference documents and appropriate page number, and attach copies. Attach explanation for any "No" responses.

The Health Center Board structure is in compliance with requirements:

	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
	<i>Reference Document</i>	<i>Page No.</i>
• Board composition	_____	_____
• Executive committee function and composition	_____	_____
• Selection of board chairperson	_____	_____
• Selection of members	_____	_____

The Health Center's Board retains its full authorities, responsibilities, and functions as prescribed in legislation/regulations:

	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
	<i>Reference Document</i>	<i>Page No.</i>
• Strategic planning	_____	_____
• Approval of the annual budget of the center	_____	_____
• Directly employs, selects/dismiss and evaluates the CEO	_____	_____
• Adoption of policies and procedures for personnel and financial management	_____	_____
• Establishes center priorities	_____	_____
• Establishes eligibility requirements for partial payment of services	_____	_____
• Provide for an independent audit	_____	_____
• Evaluation of center activities	_____	_____
• Adoption of center's health-care policies including scope and availability of services, location, hours or operation, and quality of care audit procedures	_____	_____
• Establishes and maintains collaborative relationships with other health-care providers in the service area	_____	_____
• Existence of a conflict of interest policy	_____	_____

The arrangements do not compromise the Board authorities or limit its legislative and regulatory role. *Examples of compromising arrangements are: overriding approval or veto authority by another entity; dual majority requirements; super-majority requirements; or hiring and selection of the CEO.*

Yes

No

**Staffing**

The center directly employs the CFO, CMO, and the core staff of full time primary care providers.

Yes

No

If "No," the CEO of the center retains the authority to select and dismiss staff assigned to the center. *(Please cite reference document and page number):*

*Reference Document*

*Page No.*

\_\_\_\_\_

**Contracting**

The center has justified the performance of the work by a third party. *(Please cite reference document and page number):* \_\_\_\_\_

Yes

No

Written affiliation agreement(s) comply with current DHHS policies, i.e.:

Yes

No

*Reference Document*

*Page No.*

- Contains appropriate provisions around activities to be performed, time, schedules, the policies and procedures to be followed in carrying out the agreement, and the maximum amount of money for which the grantee may become liable to the contractor under the agreement.
- Requires the contractor to maintain appropriate financial, program, and property management systems and records in accordance with 45 CFR Part 74 and provides the center, DHHS, and the U.S Comptroller General with access to such records.
- Requires the submission of financial and programmatic reports to the health center.
- Complies with federal procurement standards including conflict of interest standards.
- Reimburses affiliate contractor in excess of the going price for an item or service.
- Reimburses affiliate contractor based on FQHC's cost per encounter.
- Contract will cause an increase in cost per encounter rate.
- Is subject to termination (with administrative, contractual, and legal remedies) in the event of breach by the contractor.

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\_\_\_\_\_

\_\_\_\_\_  
Signature of Governing Board Chairperson

\_\_\_\_\_  
Date

PLEASE LIST ALL ATTACHMENTS:

PRINT, SIGN, AND MAIL TO:

The Texas Medicaid & Healthcare Partnership  
ATTN: Provider Enrollment  
PO Box 200795  
Austin, TX 78720-0795



# Texas Medicaid

Bimonthly update to the *Texas Medicaid Provider Procedures Manual*

## Contact Information



**For information about Texas Medicaid, call the TMHP Contact Center at 1-800-925-9126.**

**For information about the Children with Special Health Care Needs (CSHCN) Services Program, call the TMHP-CSHCN Contact Center at 1-800-568-2413.**



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